County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

April 29, 2010

To: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

LOS ANGELES COUNTY HOMELESS PREVENTION INITIATIVE STATUS REPORT

According to the Los Angeles Homeless Services Authority (LAHSA), Los Angeles County has the highest concentration of homelessness in the nation (50,000 people). Various social and economic factors, as well as gaps in available housing and social services, have contributed to the crisis.

On April 4, 2006, your Board approved the County Homeless Prevention Initiative (HPI) in response to this crisis. The HPI consisted of two categories of funding: (1) $15.4 million in funding for ongoing programs; and, (2) $80 million in one-time funding to develop innovative programs. Both funding categories are to focus on reducing or preventing homelessness. In approving the HPI, your Board directed the CEO to coordinate the preparation of quarterly status reports beginning in September 2006, providing your Board with implementation updates and analysis of results of the various HPI programs in reducing and preventing homelessness.

The Chief Executive Office continues to implement specific key HPI programs in partnership with County Departments of Children and Family Services, Health Services, Mental Health, Probation, Public Defender, Public Health, Public Social Services and the Sheriff, along with other agencies including the County's Community Development Commission, LAHSA, and various cities. Through December 2009, the HPI has been tremendously successful in implementing 31 programs and serving over 40,500 individuals and 18,000 families (some programs may serve the same participants).
The initiative focuses on reaching the following two goals through the six strategies shown below:

Goal 1 – Preventing Homelessness
- Housing assistance
- Discharge planning (transitional supportive services)

Goal 2 – Reducing Homelessness
- Community capacity building
- Regional planning
- Supportive services integration linked to housing
- Innovative program design

Three attachments are included with this memo:

1. Executive Summary of Fiscal Year (FY) 2009-10, Second Quarter;

2. HPI Status Report (Attachment A): The FY 2009-10 Second Quarter HPI status report includes information on program participants, services provided, and associated outcomes; and

3. Index of Programs (Attachment B): The table presents key performance indicators and budget information on each program. Following the table, each program's performance measures are included with a description of successes, challenges, an action plan, and a client success story.

This HPI report provides information about the progress of your Board's investment to decrease homelessness and inform future planning efforts. If you have any questions, please contact Kathy House, Acting Deputy Chief Executive Officer at (213) 974-4530, or via e-mail at khouse@ceo.lacounty.gov.

WTF:KH
VKD:ljp

Attachments (3)

c: Children and Family Services
Community Development Commission
Health Services
Mental Health
Probation
Public Defender
Public Health
Public Social Services
Sheriff
City of Santa Monica
Los Angeles Homeless Services Authority
Public Counsel
Skid Row Housing Trust

Los Angeles County
HOMELESS PREVENTION INITIATIVE (HPI)

FY 2009-10, OCTOBER – DECEMBER, SECOND QUARTER EXECUTIVE SUMMARY

Project Homeless Connect Day participants receive services and information at the South Los Angeles site. Staff from 17 service agencies assisted nearly 800 clients in South Los Angeles.

PROJECT HOMELESS CONNECT

On December 10, 2009, over 2,000 households participated in Project Homeless Connect (PHC) at five sites in Los Angeles County. Over 100 agencies directly assisted and referred participants to housing and a range of supportive services. Clients received clothing, health and mental health care, transportation, legal services, and linkages to education and employment opportunities. The following agencies at each site partnered with volunteers from ServeLA and staff from service organizations: Volunteers of America in East Los Angeles; PATH Achieve in Glendale; Tri Cities Mental Health in Pomona; Union Rescue Mission (URM)/EIMAGO in Downtown; and Homeless Outreach Program/Integrated Care System (HOPICS) in South Los Angeles. In addition, the County of Los Angeles HPI supported the event and implemented a new intake process to streamline referrals and data collection.

Information from participants offered providers with an opportunity to learn more about their needs. Sixty-three percent of all participants were individuals or couples and 37% were families. Thirty-two percent of families with children reported being at-risk for homelessness, and 28% previously rented with no housing subsidy. In contrast, 57% of individuals were actually homeless or chronically homeless and 15% previously rented with no housing subsidy. Individuals also were more likely to report having a disability (41% and 18% for families). Moreover, a greater percentage of families were employed (16% and 5% for individuals). The PHC events present a one-stop approach to connect people with a variety of supports and eliminate barriers to access services in a client-friendly environment. Additional PHC events in February and June 2010 are being organized in partnership with the Westside Shelter and Hunger Coalition, URM/EIMAGO, Whittier Area Recovery Network, and South Bay Homeless Coalition.

The HPI has served over 40,500 individuals and 18,000 families. For each strategy, specific outcomes and a combined total of estimated actual expenditures are listed. For both the Housing Assistance and Supportive Services Integration and Linkages to Housing strategies, cumulative results are shown.

GOAL 1: PREVENTING HOMELESSNESS

HOUSING ASSISTANCE
$10,899,999

Eviction Prevention
Moving Assistance
Rental Subsidy

Through housing assistance, individuals, youth, and families maintain permanent housing.

- **5,788 individuals and 12,440 families received housing assistance, which prevented homelessness.**

Note: A participant who received more than one type of housing assistance was counted once.

DISCHARGE PLANNING
$11,191,401

Access to Housing for Health
Homeless Release Projects
Just In-Reach Program
Recuperative Care

Clients discharged from public hospitals and jails receive case management, housing location, and supportive services.

- **3,946 clients received public benefits.**
- **225 clients placed into permanent housing.**
- **90% decrease in inpatient days and 83% decrease in ER visits a year post enrollment.**

GOAL 2: REDUCING HOMELESSNESS

COMMUNITY CAPACITY BUILDING
$12,012,032

City and Community Program (CCP)
Revolving Loan Fund

Provide 21 communities with housing development and supportive services via contracts with local housing developers and service providers.

- **3,486 individuals and 722 families received 8,785 linkages to supportive services and 1,257 housing placements.**

REGIONAL PLANNING
$4,465,683

Homeless Services
Long Beach Homeless Veterans

Helping communities address homelessness in their neighborhoods through development of housing resources and service networks.

- **Gateway and San Gabriel Valley Council of Governments (COG) presented regional plans to include 1,253 units of permanent housing.**

SUPPORTIVE SERVICES INTEGRATION AND LINKAGES TO HOUSING
$16,551,215

Case Management
Housing Locators
Multi-disciplinary Team/Access Center

Provide clients with integrated supportive services and housing. Supportive services include case management, health care, mental health services, and substance abuse treatment.

- **13,161 individuals and 6,223 families placed into emergency, transitional, and permanent supportive housing.**
- **33,798 linkages to integrated supportive services enhanced participants' well-being.**
- **10,832 individuals and families achieved greater self-sufficiency through public benefits, income support, and connections to employment opportunities.**

INNOVATIVE PROGRAM DESIGN
$19,540,379

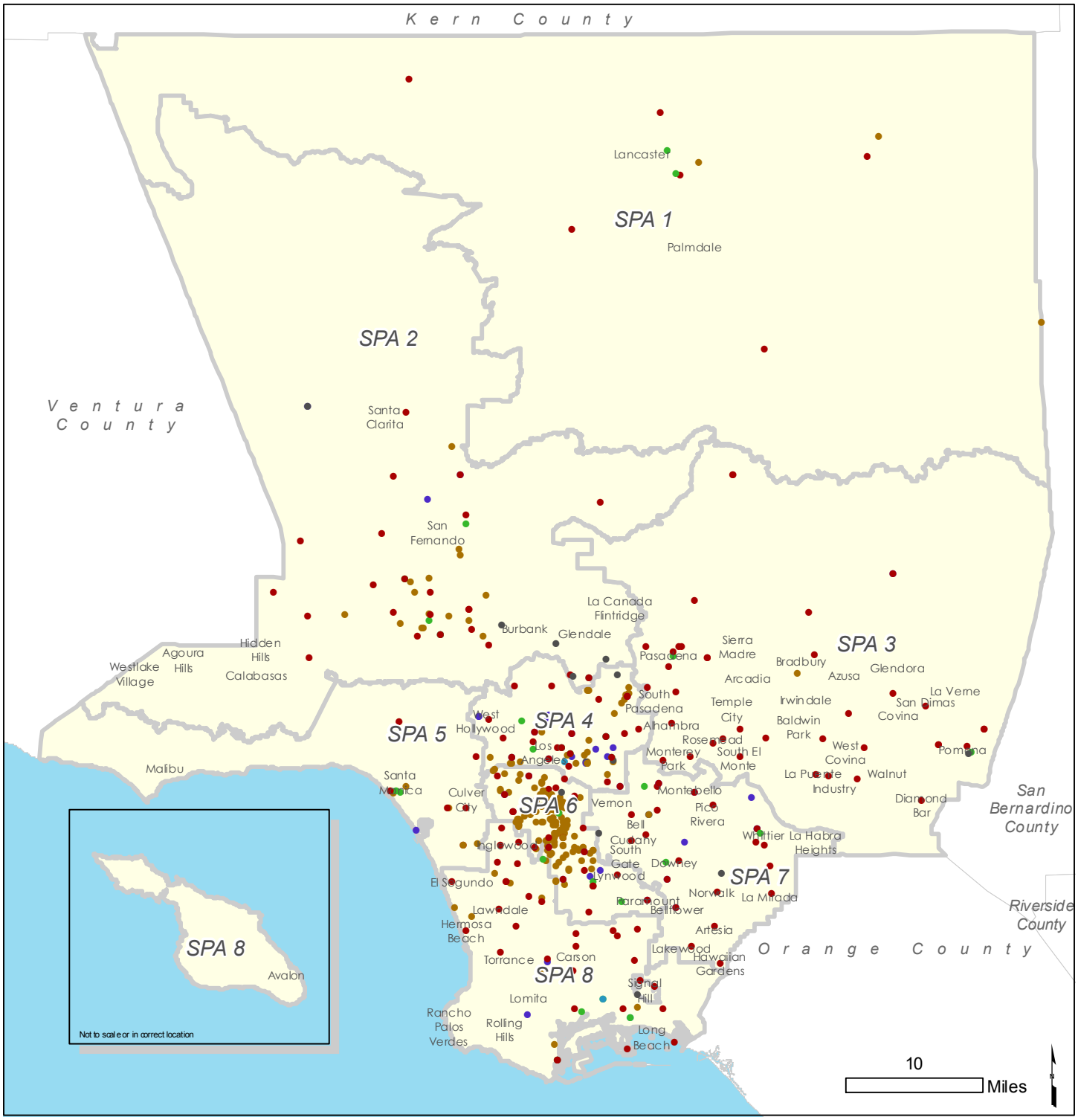
Project 50
Skid Row Families Demonstration Project
Homeless Court
Housing Resource Center
Santa Monica Service Registry

Provide access to housing and services for the most vulnerable, including chronic homeless individuals and families on Skid Row, individuals with co-occurring disorders, and homeless individuals with outstanding warrants.

- **86 chronic homeless individuals placed into permanent supportive housing.**
- **241 Skid Row families placed into permanent rental housing (93% retained at 12 months).**
- **Citations and warrants dismissed for 1,609 individuals.**
- **Over 4 million housing searches conducted.**

County of Los Angeles Regional Homeless Prevention Initiative

Housing Placement and Service Locations by Service Planning Area (SPA)



Strategy

- 1 - Housing Assistance
- 2 - Transitional Supportive Services
- 3 - Community Capacity Building
- 4 - Regional Planning
- 5 - Supportive Services Integration and Linkages to Housing
- 6 - Innovative Program Design

Notes:

i) The following HPI programs are offered Countywide:
General Relief Housing Subsidy and Case Management Project
Los Angeles County Homeless Court
Los Angeles County Housing Resource Center
Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program
Project Homeless Connect

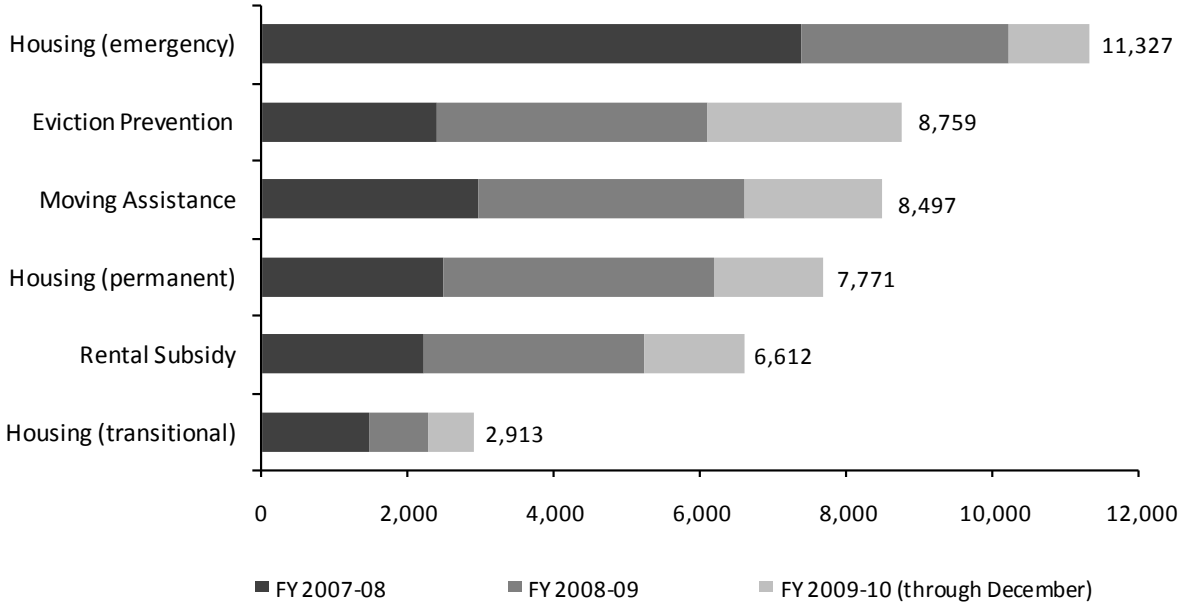
ii) Strategy 4 - Regional Planning includes San Gabriel Valley Council of Government Plan and Gateway Cities Homeless Strategy.

iii) Rental subsidies were provided to transition age youth who moved to cities in other counties, including: San Bernardino, Riverside, Kern, Orange, San Diego, Ventura, and Santa Barbara.

Map created by ISD/UR-GIS YM (562-940-2181) on 2009-05-14, HPI.mxd
Data from CEO/SIB, LACoeGIS Repository, and Thomas Bros Data.

It is the County's goal to work with community partners to further reduce and prevent homelessness. The chart below shows the number of HPI participants who received housing and financial assistance through December 2009.

HPI Participants Receiving Housing/Housing Assistance



Information about the County of Los Angeles Homeless Prevention Initiative

The Los Angeles County Board of Supervisors invested resources to address and prevent homelessness with the approval of the $100 million Homeless Prevention Initiative (HPI). The Chief Executive Office (CEO) continues to implement specific key HPI programs in partnership with County departments, the Los Angeles Homeless Services Authority (LAHSA), Community Development Commission (CDC), and various cities. To date, the HPI has been tremendously successful in implementing 31 programs and serving over 40,500 individuals and 18,000 families. The initiative focuses on reaching the following two goals through six strategies shown below:

Goal	Strategy
Preventing Homelessness	• Housing assistance • Discharge planning (transitional supports)
Reducing Homelessness	• Community capacity building • Regional planning • Supportive services integration and linkages to housing • Innovative program design

For additional information, please contact Vani Dandillaya at vdandillaya@ceo.lacounty.gov.

COUNTY OF LOS ANGELES

Homeless Prevention Initiative (HPI)
FY 2009-10, Second Quarter Status Report

TABLE OF CONTENTS

Following the **Executive Summary** of this report are two attachments.

Attachment A: Overview of HPI Status

Attachment B: Index of HPI Programs by Population *(Table on page 1)*

HOMELESS PREVENTION INITIATIVE (HPI) STATUS REPORT
FY 2009-10, Second Quarter

I. INTRODUCTION

In accordance with your Board's direction on April 4, 2006, this report provides a status update on the implementation of 31 programs included in the Los Angeles County Homeless Prevention Initiative (HPI) during October-December of FY 2009-10. The Chief Executive Office (CEO) continues to implement specific key HPI programs in participation with the Community Development Commission (CDC), the Departments of Children and Family Services (DCFS), Health Services (DHS), Public Health (DPH), Mental Health (DMH), Public Social Services (DPSS), Probation, Public Defender, and the Sheriff. Representatives from these County agencies, departments, and several partner organizations meet frequently to ensure consistent communication and integration of services and facilitate successful implementation of HPI programs serving the County's homeless population.

HPI funding has allowed for greater access to housing and supportive services for the homeless and at-risk population. This HPI status update highlights results achieved through program strategies that have served over 40,500 individuals and 18,000 families.[1] This report features components of the HPI, associated outcomes, and opportunities to strengthen County homeless coordination.

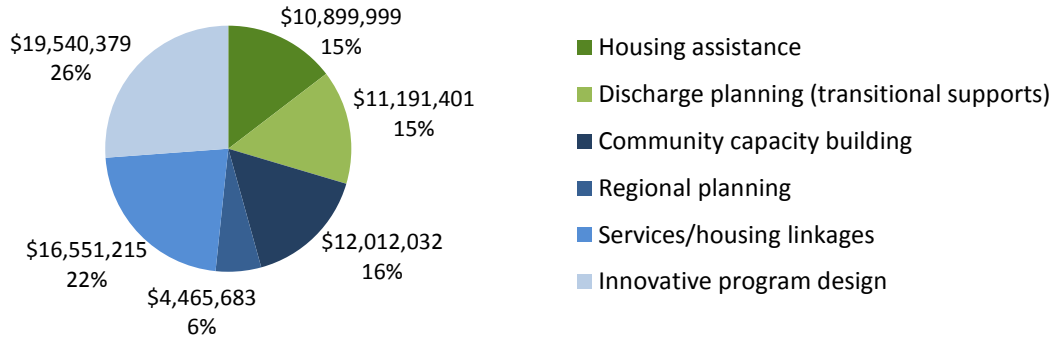
Goals and Strategies

As mentioned in the Executive Summary, the CEO continues to implement specific key HPI programs in partnership with County departments, the Los Angeles Homeless Services Authority (LAHSA), CDC, and various cities. The initiative focuses on meeting the following two goals through six strategies shown:

Goal	Strategy
Preventing Homelessness	• Housing assistance • Discharge planning (transitional supports)
Reducing Homelessness	• Community capacity building • Regional planning • Supportive services integration and linkages to housing • Innovative program design

[1] Currently, a standardized data system is not in place to determine if any client is shared across programs, therefore, the total number of participants may include a duplicate count.

Chart 1: Estimated Actual Expenditures
Total: $74,660,709*



*Estimated actual expenditures are approximately $78.6 million. Additional expenditures include: 1) Board approved operational support at $1.9 million (FY 2006-07); and 2) operational support, administrative, and evaluation costs at approximately $2.0 million. *From upper right (clockwise) beginning with Housing Assistance.*

Estimated Actual Expenditures by Strategy

In this report, total expenditures include FYs 2006-07, 2007-08, 2008-09 actual expenditures and FY 2009-10 estimated actual expenditures. The total estimated actual expenditures for the HPI programs in this report are $74.6 million. Chart I shows that 30 percent of all expenditures have been spent on the initiative's first goal to prevent homelessness. Seventy percent of all expenditures have been spent on the HPI's second goal to reduce homelessness. In addition, Chart I shows the amount expended by each strategy. For the community capacity building strategy, capital projects for housing development have been delayed due to the economic conditions, therefore, the actual expenditures are significantly less than previously estimated for FYs 2008-09 and 2009-10. Through FY 2008-09, the greatest percentage (26 percent) of actual expenditures was spent on innovative programs, including *Housing First* models for chronically homeless participants.

The following sections of the HPI status report provide an overview of participants and the initiative's progress in preventing and reducing homelessness.

II. PARTICIPANTS

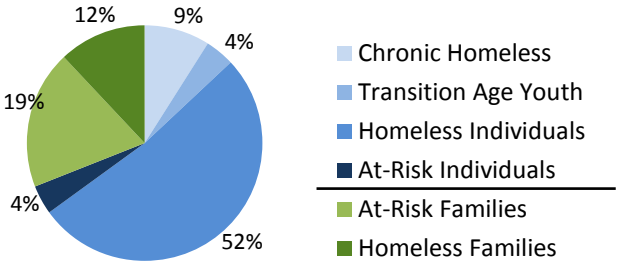
During the second quarter of FY 2009-10, 27 of 31 implemented HPI programs[2] directly served the County's homeless and nearly homeless. While several programs served more than one population, participants in 19 programs corresponded to one of five categories: homeless individuals (seven programs), chronic homeless individuals (four programs), transition age youth (two programs), homeless and at-risk families (six programs). Attachment B provides an overview of programs. To date, Table 1 shows HPI improved the lives of 40,791 individuals and 18,298 families.[3] During the second quarter, the number of families and individuals served each increased by 18 percent.

Table 1: Number of Contacts by Participant Category
FY 2009-10 through December 31, 2009

	FY 2009-10*	FY 2008-09*	FY 2007-08	Cumulative	Second Qtr. Increase
Homeless Individuals	10,049	8,722	12,206	30,977	20%
Chronic Homeless Individuals	715	2,181	2,443	5,339	11%
Transition Age Youth	224	1,100	1,122	2,446	6%
At-Risk Individuals	1,046	983	-	2,029	41%
Total for Individuals	12,034	12,986	15,771	40,791	18%
Homeless Families	1,201	1,860	3,950	7,011	16%
At-Risk Homeless Families	3,718	5,082	2,487	11,287	16%
Total for Families	4,919	6,942	6,437	18,298	18%
TOTAL	**17,056**	**19,928**	**22,208**	**59,089**	**19%**

*FYs 2008-09 and 2009-10: To calculate an unduplicated count within each program, returning participants were not included.

Chart 2: Percent by Participant Category



From upper right (clockwise) beginning with Chronic Homeless.

Chart 2 illustrates that of HPI participants, 69 percent were individuals and 31 percent were families. According to LAHSA, 12 percent of the total homeless population lives in families,[4] and similarly homeless families made up 12 percent of all HPI participants. Of all HPI participants, 52 percent were homeless adults, four percent were at-risk adults, and four percent were transition age youth. Approximately one-fourth of the homeless in the County are chronically homeless,[5] while these individuals made up nine percent of all participants.

[2] While Housing Locator and Housing Specialists programs are included, these programs are funded by CalWORKs Single Allocation and DMH Mental Health Services Act (MHSA), respectively. City and Community Program includes 21 separate programs. Project Homeless Connect participants are not included in the total as many are connected to other programs.
[3] Note most programs provided an unduplicated participant number; however, four programs included a duplicated participant count during FY 2007-08. Housing Locators/Housing Specialists are included in total participant count.
[4] LAHSA 2009 Greater Los Angeles Homeless Count.
[5] Ibid.

Participant Characteristics

During the second quarter, all 31 programs provided demographic information for program participants. Demographic information included gender, age, and race/ethnicity of participants. To obtain data on HPI participants, demographic information from new participants served during this past quarter was included. Gender information from LAHSA contracted programs was added. Due to different categorization for race/ethnicity and age, these statistics for LAHSA contracted programs are shown separately in Attachment B.

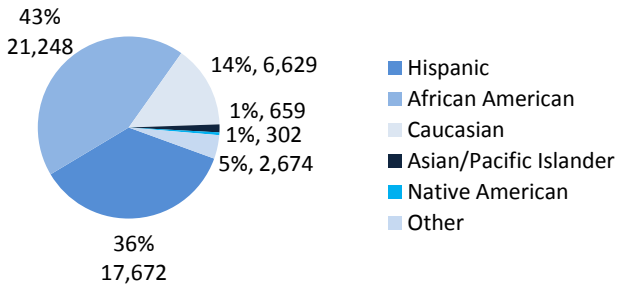
Gender

Approximately 67 percent of the homeless population in Los Angeles County consists of adult men.[6] Of the 55,357 participants whose gender was provided, 54 percent (30,009) were male and 46 percent (25,312) were female.

Race/Ethnicity

The total homeless population in Los Angeles County is 43 percent African American and 29 percent Hispanic/Latino. Chart 3 shows 43 percent of HPI participants were African American, 36 percent were Hispanic/Latino, and 14 percent Caucasian. The remaining seven percent of participants included Asian/Pacific Islander, Native American, and other racial/ethnic groups.

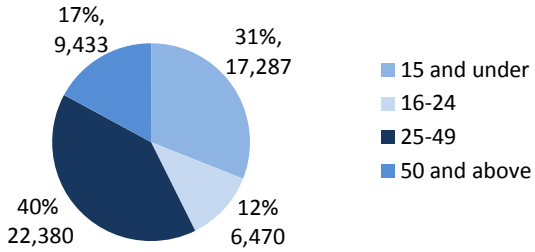
Chart 3: Race of HPI Participants (n=49,184)



Age

Of all HPI participants, a total of 40 percent was between 25-49 years of age. Chart 4 shows that of HPI participants whose age was provided, 31 percent were children 15 years of age or younger, 12 percent of participants were between the ages of 16-24, and 17 percent were 50 years of age and older.

Chart 4: Age of HPI Participants (n=55,570)



[6] LAHSA 2009 Greater Los Angeles Homeless Count.

III. GOALS, STRATEGIES, AND OUTCOMES

Goal I: Preventing Homelessness

Strategy 1 Housing Assistance $10,899,999

Through housing assistance, individuals, youth, and families maintain permanent housing.

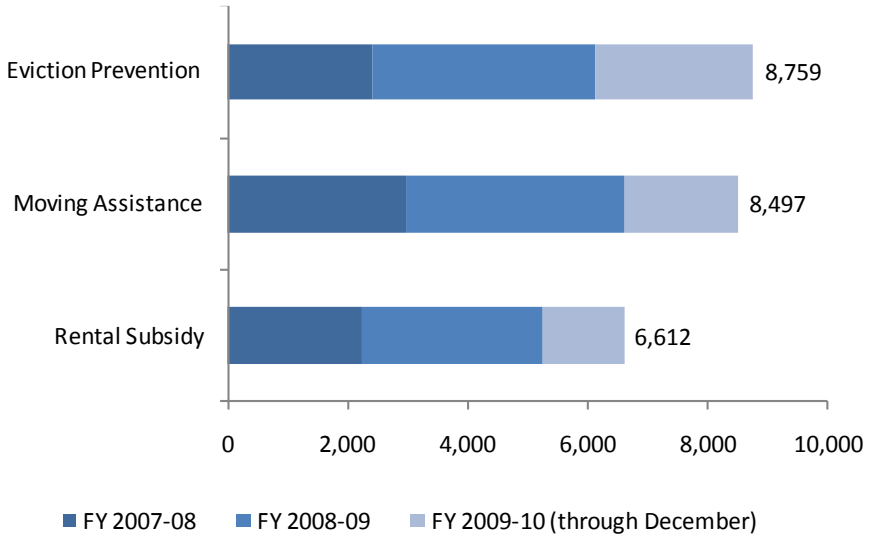
Eviction Prevention • Moving Assistance • Rental Subsidy

HPI programs provided housing assistance through moving assistance, eviction prevention, and rental subsidies; five programs focused on these services. ***Through December 2009, a total of 18,228 participants received housing assistance to secure permanent housing and prevent homelessness.*** A participant who received more than one type of housing assistance was counted once. Table 2 shows 68 percent of participants who obtained housing assistance were families, 26 percent were individuals, and six percent were transition age youth. Table 2 illustrates that a greater proportion of individuals and transition age youth received rental subsidies, whereas significantly more families obtained eviction prevention. Chart 5 shows the number of participants who received each type of housing assistance through December 2009.

Table 2: Through December 2009		Housing Assistance	Moving Assistance	Rental Subsidy	Eviction Prevention
Individuals	4,693	26%	3,224	5,175	121
Transition Age Youth	1,095	6%	583	996	2
Families	12,440	68%	4,630	385	8,586
Total participants	18,228	100%	8,437	6,556	8,709
Expenditures		**$10,899,999**	**$6,193,951**	**$902,274**	**$3,803,774**

The following participants were not included in Table 2: 60 participants who received moving assistance, 50 who received eviction prevention, and 56 who received rental subsidies.

Chart 5: Housing Assistance Provided to HPI Participants



Strategy 2 Discharge Planning (Transitional Supports) $11,191,401

Clients discharged from public hospitals and jails receive case management, housing location, and supportive services.

Access to Housing for Health (AHH) • Recuperative Care • Homeless Release Projects (DPSS-DHS and DPSS-Sheriff) • Just In-Reach Program (JIR)

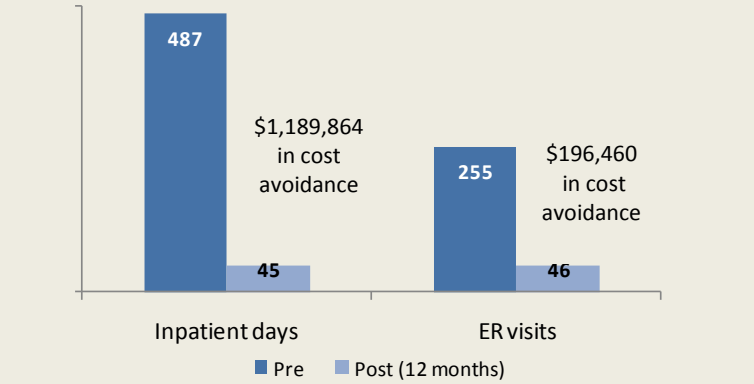
Discharge Planning for Hospital Patients

Access to Housing for Health (AHH), Recuperative Care, and DPSS-DHS Homeless Release programs provided discharge planning for hospital patients at-risk of becoming homeless. A discharge plan connected patients to services that helped them attain stable housing and a better quality of life. Both the AHH and Recuperative Care programs have shown improvements in health outcomes, such as reductions in Emergency Room (ER) visits and inpatient hospitalizations.

Outcomes

- ***Improved Health***: Since March 2007, 59 AHH clients completed 12 months with an 83% decrease in ER visits and a 90% reduction in inpatient days.
- ***Cost Avoidance:*** After 12 months, a reduction in the number AHH patients' ER visits and inpatient days resulted in the cost avoidance of over $1.3 million (Chart 6).
- ***Linkages to Public Benefits***: These programs made 600 connections to public benefits for individuals, including: Supplemental Security/Disability Income (SSI/SSDI), Medi-Cal, and General Relief (GR).
- ***Housing Stability***: AHH placed 84 individuals into permanent housing, and 97 percent (59 individuals to date) have maintained permanent housing for six months or more.

Chart 6: AHH Participant Outcomes and Cost Avoidance (n=59)



Discharge Planning for Individuals Released from Jails

Just In-Reach (JIR) and DPSS-Sheriff Homeless Release projects connected individuals to services and benefits prior to release from jail to help support steps towards building a better future, including stable housing and employment.

Outcomes

- ***Linkages to Public Benefits***: The JIR and DPSS-Sheriff Homeless Release projects served 5,789 individuals and made 3,346 connections to such public benefits as: GR, Food Stamps, SSI/SSDI, and Veteran's benefits.
- ***Housing Placement***: Housing locators have assisted 485 individuals with housing placement. Through the JIR program, 194 clients identified as homeless or chronically homeless have been released to housing, transitional living or a residential program.
- ***Transition to Communities:*** By offering case management to all JIR clients, 504 linkages have been made to job training/placement or education. The recidivism rate of JIR participants has been 34% this past year, which is half that of the general County Jail system population (70%).

Goal 2: Reducing Homelessness

Strategy ❸ Community Capacity Building $12,012,032

Provide 21 communities with housing development and supportive services via contracts with local housing developers and service providers.

City and Community Program (CCP) • Revolving Loan Fund

City and Community Program (CCP)

- Fifteen programs served 3,486 individuals and 722 families. The programs made ***8,785 linkages to supportive services and 1,257 housing placements***. Three permanent supportive housing programs showed an average housing retention rate of 84% at six months.
- Nine capital projects were funded under the CCP. The CDC is in constant contact with all developers and set up internal tracking systems to monitor project progress. As of June 2009, the Bell Shelter project was completed to provide an additional 30 beds of transitional housing with supportive services for individuals. Loan agreements are being finalized for three capital projects. The progress of many projects has been delayed by the State budget freeze, and one project (Century Villages at Cabrillo) is awaiting State funding.

Revolving Loan Fund (RLF)

- The collapse of the capital markets in 2008 negatively affected RLF operations. The Board of Commissioners approved a plan for the Los Angeles County Housing Innovation Fund (LACHIF), which has now been restructured. Current market conditions have made it difficult to attract new investors to the Fund. CDC staff continue to market and negotiate with potential investors. Hudson Oaks, a 46-unit, affordable housing senior community in the City of Pasadena is requesting $3.7 million from the Fund, which would be the first loan to be financed by the Fund.

Strategy ❹ Regional Planning $3,250,000

Helping communities address homelessness in their neighborhoods through development of housing resources and service networks.

Gateway Cities Council of Government (COG) • San Gabriel Valley COG • Long Beach Homeless Veterans

- The San Gabriel Valley Council's of Government (COG) and the Gateway Cities COG are in the process of beginning phase II of their respective initiatives. Phase II will consist of overseeing the implementation of each plan. The efforts will serve to create affordable permanent housing, interim housing, homeless services, and capacity building. The County's Chief Executive Office is creating funding agreements with the COGs and/or their contracted partner to support these efforts.
- Over the next five years, San Gabriel Valley COG's Regional Homeless Service Strategy includes an objective to create 588 units of permanent supportive housing, and PATH Partners' Gateway Cities Homeless Strategy plans to create 665 permanent supportive housing units (Attachment B, p. 67).
- Long Beach Homeless Veterans served 414 veterans this quarter. Services included: case

management, child support reduction, mental health care, and housing. The County CEO's Research and Evaluation Services' analysis suggested that the program offset $1.4 million in County services after one year. During this quarter, Single Parents United N Kids (SPUNK) closed 14 child support cases for a total arrears savings of $274,814. The City of Long Beach continued outreach efforts to homeless veterans, including ongoing referrals to the Long Beach Veterans Affairs (VA) Healthcare System HUD-Veteran Affairs Supportive Housing (VASH) Voucher program.

Strategy 5 Supportive Services Integration and Linkages to Housing $16,551,215

Clients receive integrated supportive services and housing.

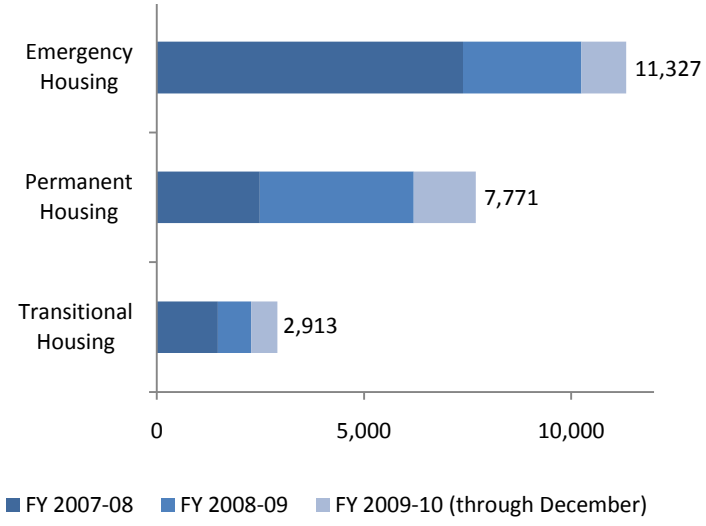
Case Management • Housing Locators • Multi-disciplinary Team/Access Center • Project Homeless Connect • Benefits Entitlement Services Team for the Homeless (B.E.S.T.)

Linkages to Housing – Chart 7 shows that a total of 7,771 participants received permanent housing. Of the total categorized by population, Table 3 shows 61 percent were families, 11 percent transition age youth, and 28 percent individuals. In contrast, 83 percent of individuals received emergency/transitional housing placement. This quarter, 19 programs placed participants into temporary housing, and participants spent an average of 79 days in temporary housing prior to permanent or transitional housing. In October 2009, the Benefits Entitlement Services Team for the Homeless (B.E.S.T.) program launched. The program's first client received approval for Supplemental Security Income only after 28 days of submitting an application to the Social Security Administration.

Table 3: Housing Placement through December 2009	Emergency/ Transitional		Permanent Housing	
Individuals	10,066	83%	1,995	28%
Transition Age Youth	303	2%	797	11%
Families	1,792	15%	4,431	61%
Total	**12,161**	**100%**	**7,223**	**100%**

Services not categorized by population above: 548 who were moved into permanent housing; 1,343 who were moved into transitional housing; and 736 who were placed into emergency housing.

Chart 7: HPI Participants Moved into Housing



Supportive Services Integration – Participants received supportive services in three categories: 1) employment/education, 2) benefits advocacy and enrollment assistance, and 3) health and human services.

Employment/Education Services and Support

Through December 2009, 22 HPI programs reported a total of 2,478 participants received job and/or education related supports (Table 4). Sixty percent of these participants received job training, referrals, or related resources. Participants in these programs included transition age youth, chronic homeless individuals and families on Skid Row, and participants with co-occurring disorders. As programs continue to make linkages to job and education related services and build infrastructure for data collection, these numbers have increased. By supporting the employable homeless to overcome barriers in obtaining and maintaining employment, more individuals have attained greater self-sufficiency.

Table 4: Jobs/Education	FY 2009-10	Cumulative*	Percent
Job training/referrals/resources	596	1,485	60%
Education (course, class, books)	171	558	22%
Job placement (employment)	137	435	18%
Total number of services provided:	**904**	**2,478**	**100%**

*Cumulative includes: FYs 2008-09 and 2009-10 through September 30, 2009.

Benefits Advocacy and Enrollment Assistance

For participants who entered programs in need of specific public benefits, 26 HPI programs reported enrolling homeless individuals and families. Table 5 shows that through December 2009, 5,087 homeless individuals were enrolled into General Relief, which consisted of 61 percent of all benefit enrollments. Eleven percent of participants were enrolled into Supplemental Security/Disability Income (SSI/SSDI), and 12 percent received Shelter Plus Care or Section 8 to secure permanent housing. This quarter, enrollments increased significantly for several benefits. The increase in number of HPI participants who enrolled into General Relief, SSI/SSDI, and Shelter Plus Care each doubled in comparison to the cumulative total last quarter.

Table 5: Benefits	FY 2009-10	Cumulative*	Percent
General Relief (and Food Stamps)	831	4,348	52%
SSI/SSDI	388	925	11%
General Relief only	140	739	9%
Shelter Plus Care	253	615	7%
Medi-Cal or Medicare	217	510	6%
Food Stamps only	205	394	5%
Section 8	107	371	5%
CalWORKs	165	325	4%
Veterans	86	127	2%
Total number of benefits provided:	**2,392**	**8,354**	**100%**

*Cumulative includes: FYs 2008-09 and 2009-10 through September 30, 2009.

Supportive Health and Human Services

Through the first quarter of FY 2009-10, 31 programs made 33,798 linkages between participants and supportive health and human services. These programs served homeless and chronic homeless individuals, homeless families, and transition age youth. Table 6 shows 22 percent (7,514) of these HPI participants received case management, which was the most frequently reported supportive service. Followed by case management, 21 percent of linkages were for health care (7,261), and 17 percent (5,830) were for mental health care. Another nine percent of these linkages connected participants to transportation services, including bus tokens and public transportation.

With 69 percent of the homeless population having a mental illness, substance abuse problem, or AIDS/HIV-related illness,[7] linking these individuals and families with health care, mental health care, and substance abuse services is critical. Additionally, with the Recovery Act's Homelessness Prevention and Rapid Re-Housing Program (HPRP) funds, the County has expanded services to assist families and individuals with credit repair, legal assistance, and money management. In a 2009 HPI survey, providers also indicated interest in improving access to child care, law enforcement, and employment support.

Twenty-eight programs reported providing case management services, and 17 programs selected the most intense level of case management. The HPI Report Form asked about the level of case management provided, with level one assessing the client and level three assisting with supported referrals and counseling.[8] Hours provided to each participant per month ranged from 45 minutes to 493 hours (average of 77 hours) with an average caseload of 30 cases per case manager.

Table 6: Supportive Services	FYs 2008-09 and 2009-10 (through December)	Percent	FY 2007-08*
Case management	7,514	22%	2,257
Health care	7,261	21%	183
Mental health care	5,830	17%	615
Transportation	3,178	9%	182
Life skills	2,872	8%	676
Alternative court	1,739	5%	286
Resident rights/responsibilities	1,299	4%	-
Substance abuse treatment	966	3%	130
Social/community activity	987	3%	51
Food vouchers/food	898	3%	414
Recuperative care	537	2%	45
Other**	323	1%	5
Clothing/hygiene	230	1%	80
Legal services	164	1%	15
Total number of services provided to participants:	**33,798**	**100%**	**4,939**

* For FY 2007-08, this report includes LAHSA contracted programs that provided referrals to mental health care (including domestic violence counseling) and substance abuse treatment.

**Other services include: auto insurance, driver's license release, identification card, and credit repair.

[7] LAHSA 2009 Greater Los Angeles Homeless Count.

[8] Post PA. Developing Outcome Measures to Evaluate Health Care for the Homeless Services. National Health Care for the Homeless Council. May 2005.

Strategy ❻ Innovative Program Design $19,540,379

Provides access to housing and services for the most vulnerable, including chronic homeless individuals and families on Skid Row, individuals with co-occurring disorders, and homeless individuals with outstanding warrants.

Project 50 • Santa Monica Service Registry • Skid Row Families Demonstration Project • Homeless Courts • Housing Resource Center

INNOVATIVE PROGRAM OUTCOMES

Housing First Models

- **Housing stability**: On average, *Housing First* models showed a successful 90 percent housing retention rate for individuals and families in permanent housing for six or more months. Housing First programs include: Project 50, Skid Row Families Demonstration Project, and the Santa Monica Service Registry.
- **Increased income**: After one year, Project 50 participants showed a 56 percent increase in benefits since enrollment.
- **Improvement in overall health and well-being**: At the end of one year, Project 50 participants spent significantly fewer days in ERs, hospitals, and jails with considerable cost savings for the County.

Homeless Courts

- **Pathways to self-sufficiency**: Ninety-three percent of Homeless Court participants had their warrants or citations dismissed, and they have been able to move forward by securing employment, reconnecting with their families, and planning for their future.

Los Angeles County Housing Resource Center (LACHRC)

- **Information sharing**: Over 4 million searches for housing listings have been conducted online.

The HPI Report Form requested for programs to report on three outcome areas for participants receiving services for 6, 12 and 18 months. The three outcome areas were: 1) housing stability, 2) education and employment status, and 3) health and well-being. Seventeen programs that served chronic homeless individuals, transition age youth, and homeless individuals and families reported on these longer-term outcome areas.

Point in time outcomes for this past quarter at 6, 12, or 18 months post enrollment:

- **Housing stability**: A total of 1,818 participants continued to live in permanent housing and 1,463 continued to receive rental subsidies.
- **Employment/education**: A total of 140 participants obtained employment, 194 maintained employment, and 159 enrolled in an educational program.
- **Health and well-being**: The following number of participants continued to receive these services for six months or more: 2,700-case management; 5,101-health care; 1,325-mental health services; and 296-substance abuse treatment.

A brief description of each innovative program:

- **Project 50** – The project is a successful collaboration that includes over 24 government and non-profit agencies. Based on Common Ground's *Street to Home* strategy, Project 50 integrates housing and supportive services for vulnerable, chronic homeless individuals living near downtown Los Angeles on Skid Row. A year after its launch, the pilot successfully moved 50 vulnerable, chronic homeless individuals off of Skid Row with an impressive housing retention rate of 86 percent. Moreover, significant decreases in hospitalizations and emergency room visits indicate improved health and behavioral health outcomes. In addition to improving the quality of life for these 50 individuals, estimates show considerable cost savings as a result of fewer days spent in ERs, hospitals, and jails.

- **Skid Row Families Demonstration Project** – A total of 241 families have been placed into permanent housing. Of these families, 93 percent have successfully maintained permanent housing for six or more months (221 have maintained their permanent housing for 12 months or more, and three families have maintained permanent housing for seven to 12 months). For the first six months in permanent housing, families are offered home-based case management. Consistent contact has enabled the Housing First Case Managers to develop positive relationships based on trust. Case management has included linking families to various supportive services, including: community resources, mental health referrals, school referrals, job training referrals, money management, and financial planning. After six months of home-based case management to help families stabilize, the majority of families received follow-up phone calls to ensure they are doing well and are not in crisis.

- **Homeless Courts** – A total of 1,609 individuals have had their warrants or citations dismissed as a result of successful completion of mental health and/or substance abuse treatment requirements of the Los Angeles County Homeless Court and Santa Monica Homeless Community Court. In addition, 12 individuals have graduated from the Co-Occurring Disorders Court to have charges dismissed. As a result of having outstanding warrants, citations, or charges resolved, these individuals have been able to move forward by securing employment, reconnecting with their families, and planning for their future. For example, one participant obtained his GED, became a certified cook and hopes of owning his own restaurant. Another participant said that the program has changed his life by helping him achieve sobriety for over 17 months and reunite with his family.

- **Los Angeles County Housing Resource Center (LACHRC)** – The online database provides information on housing listings for public users, housing locators, and caseworkers. Over 4 million searches have been conducted by users to receive listings. The LACHRC is an excellent example of using technology to make information more accessible, and clients are very grateful for this service. In October 2009, the LACHRC added a pre-screening feature to determine HPRP program eligibility and further improve system navigation for clients.

IV. PROGRAM NARRATIVE (included in Attachment B)

Each quarter, programs provide information on successes, challenges, and action plans. A review has identified four common themes in implementing strategies to reduce homelessness: collaborative partnerships, innovative processes, outreach strategies, and leveraged funds.

Client Success Stories

This quarter, three featured stories of City and Community Program participants illustrate the life-changing impact of compassionate case management and permanent supportive housing.

Veteran received assistance from OPCC HEARTH and moved into his own apartment

Client J, a 62-year-old veteran, had been chronically homeless for 20 years due to financial issues and mental illness. At the beginning of 2009, he was connected to OPCC Project HEARTH case management and primary health care. Initially he was resistant to housing, and staff worked diligently, encouraging him to access available resources. After accepting much support through OPCC Project HEARTH, the client entered the VASH Program, a federal housing program for homeless veterans. He received his VASH housing voucher in December 2009 after months of waiting and located an apartment in Santa Monica. He moved into his first apartment in January 2010, after living two decades on the street.

Homes for Life Foundation (HFLF) – Vanowen Apartment tenant gained stability and independence

Client L is currently a tenant of HFLF, Vanowen Apartments. Before L occupied the apartment, he had his share of tumultuous events that included incarceration, physical injury, mental health struggles and other challenges. The client recalled that he was on the waiting list for HFLF for over three years. During that time, he was in several transitional living programs, which provided him with a warm safe place to sleep, but he felt that he was not living up to his potential in those environments. When he was accepted to HFLF, he was a bit overwhelmed, but after just three months in the apartments he felt that he had a new sense of purpose. Currently, the client is thriving at the HFLF Vanowen Apartments. He regularly accesses the services provided at the wellness center next door. He volunteers on a regular basis at a retirement home close to the apartments. He has taken job skills classes as well as held a part-time job. The client also made a large commitment to finding a creative outlet, by continually writing music, poetry and shorts stories which he reads with great pride to other residents and staff. The client sees the apartment as a community. He invites people over for dinner and takes great interest and care with all the residents. Client L is a great example of how an individual in the right environment can be inspired to better their life. In closing, here is a quote from Client L. When asked what the HFLF apartments meant to him, he stated “HFLF does not guarantee I will not slip back into my mental illness, but it does give me the best chance of succeeding in all that I want to do with my life. I could not ask for a more supportive and caring place to live.”

Special Service for Groups (SSG) – SPA 6 Community Coordinated Homeless Services Program supported client towards self-sufficiency

A middle-aged client is a testament to the current economic downfall. The client found herself homeless after not only being laid off, but also because her landlord sold the property in which she was living in without providing proper notice. The client immediately began receiving supportive services once admitted into the program. However, she was unsure of being placed in a shared living space through a transitional housing partner. The client insisted on finding temporary shelter elsewhere. She slept in her car, with friends and family, and she would pay for a hotel with her unemployment earnings. While in the program, she referred a friend to the transitional housing component, and her friend began saving her money. Soon after she noticed her friend’s progress toward financial and housing security, the client agreed to be placed with a housing partner Community Minded Business. Approximately 45 days after being in transitional housing, the client was able to regain stability by securing employment, adhering to a savings plan, securing a new permanent residence, and creating an emergency savings deposit to prevent future unexpected financial crisis. Through her determination and recognition of the program’s benefits, the client successfully took steps to change her life.

V. UPDATES ON COUNTY HOMELESS COORDINATION

OpenMRS-LA Project

Currently, it is estimated that 3,802 homeless people live in the 52-block-neighborhood of Downtown Los Angeles.[9] Coordinated services would ensure that individuals receive the appropriate level of care and that they do not receive duplicate services by multiple agencies. To improve coordination of care and treatment, the he`alth and social services agencies in the area formed the Skid Row Homeless Healthcare Initiative. The Initiative determined that an electronic database for sharing information about encounters and providers would improve coordination of care to benefit individuals using the system as well as the overall population. The JWCH Institute, Inc. (JWCH Institute) applied for and received funding from LA Care's Robert E. Tranquada, MD Health Care Safety Net Award to establish an electronic system for sharing patient information. OpenMRS, an open source electronic medical record system framework, was selected by the JWCH Institute as the platform. A customized implementation, "OpenMRS-LA," was launched as the electronic system that would be used by multiple agencies and providers to track and manage medical, mental health and patient/client encounter information.

On February 16, 2010, the County Board of Supervisors approved the OpenMRS-LA Memorandum of Understanding (MOU). The MOU allows participating departments to enhance the care and treatment provided to individuals of the Skid Row area by providing legally permissible access to the OpenMRS-LA database. The database is a collective repository of client service information to enhance the level of treatment and coordination of care. This action authorized the CEO and the Directors of the DHS, DMH, and DPH to enter into a MOU with the JWCH Institute to participate in the OpenMRS-LA Project of the Skid Row Homeless Health Care Initiative. As a result, the participating departments can legally access and input information regarding the health, housing, and other social services provided to individuals in the Skid Row area of Downtown Los Angeles.

Strengthening County Homeless Coordination

On November 17, 2009, the County Board of Supervisors passed a motion instructing the CEO, with assistance from DCFS, DHS, DMH, DPSS, the CDC, and LAHSA, to develop recommendations on how to strengthen the CEO's ability to oversee, coordinate and integrate Countywide homeless service delivery so that homeless individuals and families can more successfully find safe and permanent housing. In response, a CEO report to the Board on January 4, 2010 made three main recommendations to strengthen the County's homeless strategy: 1) leverage funds to maximize resources; 2) coordinate a regional approach among partners; and 3) address cost avoidance.

Significant progress has been made to develop collaborative working partnerships with multiple public and private agencies and philanthropic organizations. It is the County's intent to work with the SNHA to put together an action plan with a timeline that would continue to align resources, while at the same time not increase Net County Cost (NCC) and maximize resources to serve homeless individuals and families. The CEO will continue to develop partnerships with cities and communities throughout the County to create regional solutions to address homelessness. Monthly Board briefings and homeless coordination meetings include staff from Board offices, County departments, LAHSA, CDC, and several cities to provide updates on the HPI budget and programs. The forum is an opportunity to discuss various homeless issues. Each of these efforts and the Board's continued investment will ensure that the initiative to reduce homelessness in Los Angeles in successful.

[9] LAHSA 2009 Greater Los Angeles Homeless Count.

VI. Acknowledgements

We would like to acknowledge the time and effort of the following who have contributed to the collection and review of the HPI program data included in this report.

A Community of Friends	Dora Leong Gallo Nancy Neilson Rebecca Ricketts Dorene Toutant
Beyond Shelter	Zoe Ellas Tanya Tull
Catalyst Foundation for AIDS Awareness and Care	Elizabeth Gomez Susan Lawrence
Century Villages at Cabrillo	Brian D'Andrea Aaron Wooler
Chief Executive Office, County of Los Angeles	Julie Beardsley Lynn Cao Michael Castillo Rosemary Gutierrez Maggie Ly
City of Long Beach	Rene Miyasato Susan Price
City of Pasadena	Anne Lansing
City of Pomona	Jan Cicco
City of Santa Monica	Stacy Rowe Setareh Yavari
CLARE Foundation, Inc.	Bridget Goldberg
Cloudbreak Compton, LLC	Scott Fichter
Community Development Commission (Los Angeles County)	Virginia Adame Terry Gonzalez Linda Jenkins Larry Newnam Elena Quon Carolina Romo Lois Starr Scott Stevenson
Department of Children and Family Services, County of Los Angeles	Bedrae Davis Theresa Rupel Rhelda Shabazz
Department of Health Services, County of Los Angeles	Elizabeth (Libby) Boyce Rowena Magana Vicki Nagata Leepi Shimkhada
Department of Mental Health, County of Los Angeles	Maria Funk Adrienne Gee Juataun Mark Mary Marx Jaime Nahman John Snibbe Reina Turner
Department of Public Social Services, County of Los Angeles	Consuelo Ayala LaShonda Diggs Ken Krantz Charlotte Lee Judith Lillard Dorothea Manns Charles Medlin

Department of Public Social Services (continued)	Antonio Roldan Jose Salgado
Gateway Cities Council of Governments	Joel John Roberts (PATH Partners) Margaret Willis
Homes for Life Foundation	Deborah Gibson
JWCH Institute, Inc.	Al Ballesteros Paul Gregerson Itohan Oyamendan
Los Angeles Homeless Services Authority (LAHSA)	Steve Andryszewski Rachel Citron Michael Nailat
National Mental Health Association of Greater Los Angeles	Lesley Braden Jamie Gonzalez Sarah Tower
Ocean Park Community Center (OPCC)	Cherry Castillo Debby Maddis
PATH Achieve Glendale	Jerome Nilssen LaViva Primm Natalie Profant Komuro
Probation Department, County of Los Angeles	Hania Cardenas Michael Verner Maria Vicente
Public Counsel Law Center	Jennifer Amis David Daniels Sarah Evans Paul Freese
Salvation Army	Alen Davtian
San Gabriel Valley Council of Governments	Nicholas Conway Bekah Cooke
ServeLA	Adrian Koehler
Sheriff's Department, County of Los Angeles	Lt. Edward Ramirez
Skid Row Housing Trust	Katherine Hill Shannon Parker
Southern California Alcohol and Drug Programs, Inc. (SCADP)	Heidi Hobart-Ferraro
Southern California Housing Development Corp. of Los Angeles	Sandra Peterson
Special Service for Groups (SSG)	Cheryl Branch Tonia Johnson (HOPICS) Carlos Moran
Step Up on Second	Aaron Criswell Tod Lipka
Superior Court of California (County of Los Angeles)	Jessica Delgadillo Ken Kallman Saida Lopez
Tri Cities Mental Health	Gilbert Saldate
Union Rescue Mission	Jessica Brown-Mason Sara Farnsworth Carrie Gatlin Bert Paras
Volunteers of America of Los Angeles	Jim Howat Veronica Lara Alma Martinez
Women's and Children's Crisis Center	Dolores Salomone

Pg. Strategy

Table of Homeless Prevention Initiative (HPI) Programs

Attachment B

Pg.	Strategy	Program	Indicator (to date)	Target	Funding	Budget
		Families (I)				
3	❶	1. Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	8,483 families received eviction prevention to prevent homelessness	2,079	One-Time	$500,000
	❶	2. Moving Assistance for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families	4,347 families received moving assistance and permanent housing	1,305 450	One-Time	$1,300,000
	❶	3. Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	211 families received rental subsidies to prevent homelessness	1,475	One-Time	$4,500,000
5	❺	4. Housing Locators	573 families placed into permanent housing	n/a	*DPSS*	$1,930,000
6	❻	5. Skid Row Families Demonstration Project	241 families placed into permanent housing	300	Board Approved	$9,212,000
8	❺	6. Multi-disciplinary Team Serving Families	283 families received case management services	n/a	Ongoing	$494,000
		Transition Age Youth (II)				
10	❶	7. Moving Assistance/Rental Subsidies for TAY – DCFS	494 TAY received rental subsidies	335 3yr	One-Time	$1,750,000
10	❶	8. Moving Assistance/Rental Subsidies for TAY – Probation	366 TAY received rental subsidies	335 3yr	One-Time	$1,750,000
		Individuals (III)				
12	❷	9. Access to Housing for Health (AHH)	84 clients placed into permanent housing 90% decrease in inpatient days; 83% in ER visits	115 cap	Board Approved	$3,000,000
14	❺	10. Benefits Entitlement Services Team for the Homeless (B.E.S.T.)	82 individuals received case management	Individuals	One-Time	$2,000,000
15	❻	11. Center for Community Health Downtown Los Angeles	3,744 individuals received health/mental health care	n/a	Ongoing	*$186,000
16	❺	12. Co-Occurring Disorders Court	53 individuals placed into transitional housing	n/a	Ongoing	$200,000
18	❷	13. DPSS General Relief Housing Subsidy & Case Management Project	3,040 homeless GR participants received housing subsidies for housing placement	900 time	Ongoing	$4,052,000
20	❷	14. DPSS-DHS Homeless Release Project	441 potentially homeless participants received benefits	n/a	Ongoing	$588,000
20	❷	15. DPSS-Sheriff's Homeless Release Project	3,150 potentially homeless individuals received benefits	n/a	Ongoing	$1,171,000
21	❺	16. Homeless Recuperative Care Beds (DHS)	424 individuals were served through this program 71% decrease in hospitalizations; 30% in ER visits	490/2yr	One-Time	$2,489,000
23	❷	17. Housing Specialists (most clients are individuals)	711 placed into permanent housing	n/a	*DMH MHSA*	$923,000
24	❹	18. Just In-Reach Program	206 individuals received public benefits	Individuals 400/2 yr	One-Time	$1,500,000
27	❻	19. Long Beach Services for Homeless Veterans (mostly individuals)	191 veterans received case management services	n/a	Ongoing	$500,000
30	❶	20. Los Angeles County Homeless Court Program	1,491 individuals with citations or warrants dismissed	n/a	Ongoing	$379,000
32	❻	21. Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program	332 single adults received moving assistance to prevent homelessness	until 2,000	One-Time	$1,100,000
33	❻	22. Project 50	58 chronically homeless placed into permanent housing	50	One-Time	$3,600,000
35	❻	23. Santa Monica Homeless Community Court	118 individuals with citations or warrants dismissed	90	Board Approved	$571,000

Table of Homeless Prevention Initiative (HPI) Programs

Attachment B

	Program	Indicator (to date)	Target	Funding	Budget
37 ❻	24. Santa Monica Service Registry (programs a and b)	74 chronic homeless individuals have participated	n/a	3rd District	$1,178,000
	Multiple Populations (IV)				
41 ❻	25. Los Angeles County Housing Resource Center	Over 4 million housing searches conducted	n/a	Ongoing	$202,000
42 ❺	26. LAHSA contracted programs	7,745 placements into housing	n/a	One-Time	$1,735,000
42 ❺	27. PATH Achieve Glendale (families and individuals)	242 placements into permanent housing	n/a	One-time	$150,000
44 ❸	28. Pre-Development Revolving Loan	Restructuring occurred in January 2010	n/a	One-Time	$20,000,000
45 ❺	29. Project Homeless Connect	In December, 2,065 households connected to services	n/a	One-Time	$45,000
46 ❸	30. **City and Community Program - CCP (V)**	$11.6 m capital, $20.6 m City Community Programs	Multiple	One-Time	$32,000,000
69 ❹	31a. **San Gabriel Valley Council of Governments - COGs (VI)**	Final report completed in March 2009	n/a	Ongoing	$200,000
69 ❹	31b. Gateway Cities Homeless Strategy	Final report completed in March 2009	n/a	Ongoing	$135,000
	HPI Funding Total (excludes Board approved operational support (FY 2006-07), administrative and evaluation costs) *Ongoing costs expected to be $76,000				**$99,340,000**

46 ❸	***City and Community Program (CCP) Funds***	**Service ($)**	**Capital ($)**
	A Community of Friends – Permanent Supportive Housing Program	$1,800,000	
	Beyond Shelter Housing Dev. Corp. – Mason Court Apartments		$680,872
	Catalyst Foundation for AIDS Awareness and Care – Expansional Supportive Services Antelope Valley	1,800,000	
	Century Villages at Cabrillo, Inc. – Family Shelter EHAP I & II		1,900,000
	City of Pasadena – Nehemiah Court Apartments	102,685	858,587
	City of Pomona – Community Engagement & Regional Capacity Building	1,239,276	
	City of Pomona – Integrated Housing & Outreach Program	913,975	
	CLARE Foundation, Inc. – 844 Pico Blvd., Women's Recovery Center		2,050,000
	Cloudbreak Compton LLC – Compton Vets Services Center	322,493	1,381,086
	Homes for Life Foundation – HFL Vanowen	369,155	369,155
	Nat'l Mental Health Assoc. of Greater L.A. – Self Sufficiency Project for Homeless Adults and TAY Antelope Valley	900,000	
	Nat'l Mental Health Assoc. of Greater L.A. – Self Sufficiency Project for Homeless Adults and TAY Long Beach	1,340,047	
	Ocean Park Community Center (OPCC) – HEARTH	1,200,000	
	Skid Row Housing Trust – Skid Row Collaborative 2 (SRC2)	1,800,000	
	So. California Housing Development Corp. of L.A. – 105th and Normandie	200,000	600,000
	So. California Alcohol & Drug Programs, Inc. (SCADP) – Homeless Co-Occurring Disorders Program	1,679,472	
	Special Service for Groups (SSG) – SPA 6 Community Coordinated Homeless Services Program	1,800,000	
	The Salvation Army – Bell Shelter Step Up Program		500,000
	Union Rescue Mission – Hope Gardens Family Center	756,580 1,096,930	646,489
	Volunteers of America of Los Angeles – Strengthening Families	1,000,000	
	Women's and Children's Crisis Shelter	300,000	
	Total for Service and Capital	$18,620,613	$8,986,189
	Grand Total for CCP*	**$27,606,802**	

**Actual total of $32 million includes administrative costs.*

For this report, unless specified: Fiscal Year (FY) refers to the first and second quarters of FY 2009-10 (July 1, 2009 – December 31, 2009). Cumulative refers to the number of clients served to date. Note: complete demographic information may not have been provided.

I. PROGRAMS FOR FAMILIES

1, 2, 3) DPSS Programs: Moving Assistance, Eviction Prevention, and Rental Subsidy

Goal: Assist families to move into and/or secure permanent housing.

Budget: (One-Time Funding)

1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families (EAPE)	$500,000
2) Moving Assistance for CalWORKs Non- Welfare–to-Work and Non-CalWORKs Homeless Families	$1,300,000
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	$4,500,000

Table A.1: DPSS Services for Families by Program
FY 2009-10, through December 31, 2009

Program (unduplicated count)	FY	Cumulative
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	2,467 received eviction prevention	8,483 received eviction prevention
2) Moving Assistance for CalWORKs Non- Welfare-to-Work and Non-CalWORKs Homeless Families	993 received moving assistance and permanent housing	4,347 received moving assistance and permanent housing
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	Program ended in FY 2008-09.	211 received rental subsidies for permanent housing

Table A.2: DPSS Measures by Program
FY 2009-10, through December 31, 2009

Program (unduplicated count)	Number of applications received		Percent of applications approved		Average amount of grant	
	FY	To date	FY	To date	FY	FY 08-09
1) Emergency Assistance to Prevent Eviction for CalWORKs Non-Welfare-to-Work Homeless Families	3,367	12,370	73%	69%	$691	$649
2) Moving Assistance for CalWORKs Non- Welfare–to-Work and Non-CalWORKs Homeless Families	1,205	6,127	82%	71%	$843	$821
3) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families	137	215	96%	99%	-	$427

Each program reported an average of three business days to approve an application.

January - December 2009	Moving Assistance	Rental Subsidy	Emergency Assistance
Homeless/At-Risk Families	1,758	58	4,174
Female	3,200	105	7,396
Male	2,136	91	5,705
Hispanic	2,053	85	7,592
African American	2,948	81	4,801
White	131	23	360
Asian/Pacific Islander	83	2	141
Native American	6	2	9
Other	115	3	198
15 and below	3,344	121	5,008
16-24	534	11	915
25-49	1,451	64	1,897
50+	7	-	9

1) Moving Assistance (MA) for CalWORKs Non-Welfare-to-Work and Non-CalWORKs Homeless Families

Successes: During this past quarter through the MA program, a total of 444 families received financial assistance to secure permanent housing and/or received assistance for one or more of the following: a) utility turn-on fees; b) truck rental; and c) appliance purchases (stove and/or refrigerator).

Challenges: Finding safe and affordable housing is a big challenge for low-income families in Los Angeles County.

Action Plan: Utilize and promote the use of websites such as the Los Angeles County Housing Resource Center to assist families in locating safe and affordable housing.

Client Success Story: With the financial assistance received through the MA program, a mother was able to secure permanent housing for herself and her daughter. Now that the family has resolved the housing issue, the mother is focusing on job search and education.

2) Rental Subsidy for CalWORKs and Non-CalWORKs Homeless Families

Successes: This program has provided rental subsidy assistance to 58 families for this quarter.

Challenges: Due to budget constraints, this program was terminated for new program applicants effective February 28, 2009.

Action Plan: The action plan is to continue assisting families that were approved prior to the termination of this program (2/28/09).

Client Success Story: A CalWORKs family who became homeless due to a domestic violence situation accessed GAIN supportive services after resolving a CalWORKs program sanction with the assistance of the participant's HCM. The participant found permanent housing from a listing the HCM provided to her from the Socialserve.com/restricted area search. The participant qualified for Permanent Homeless Assistance, Moving Assistance and the 12 Month Rental Subsidy Program. Through the collaborative efforts of the DPSS HCM, the Housing Resources Eligibility Unit, GAIN and LAHSA (shelter), this family was able to move from a DV shelter into permanent housing.

3) Emergency Assistance to Prevent Eviction (EAPE) for CalWORKs Non-Welfare-to-Work Homeless Families

Successes: Through the EAPE program, a total of 1,273 families at-risk of homelessness received assistance to maintain their current housing and/or maintain their utility services this quarter.

Challenges: Due to the high volume of applications for EAPE, funding is always a challenge.

Action Plan: DPSS continues to evaluate families requesting assistance with past-due rent and/or utilities for the State-approved Homeless Assistance Arrearages Payment program in order to spend less HPI funds for EAPE.

4) Housing Locators - DPSS

Goal: Assist families to locate and secure permanent housing.
Budget: $1.93 million (DPSS CalWORKs funding)

Table A.3: Housing Locators Measures
FY 2008-09, through December 31, 2008

(unduplicated count)	FY	Cumulative
Homeless Families	471	1,685
Housing (permanent)	210	573
Number of referrals to Program	471	1,685
Average time to place family (days)	60-180	60-180

Successes: Through the assistance of the Housing Locators, 210 families were placed into permanent housing during October-November 2008. No placements were made in December 2008.

Challenges: Due to budget constraints, the Housing Locators contract has been officially terminated effective December 15, 2008. Referrals to the Housing Locators program ended effective October 15, 2008.

Action Plan: The Housing Locator's program contract was terminated effective December 15, 2008.

5) Skid Row Families Demonstration Project

Goal: Locate 300 families outside of Skid Row and into permanent housing.
Budget: $9.212 million (Board Approved Funding)

Table A.4: Skid Row Families Demonstration Project Participants and Services
FY 2009-10, through December 31, 2009

(unduplicated clients)	Cumulative (3/31/09)		Cumulative
Homeless Families	300	Moving assistance	175
(individuals)	1,084	Eviction prevention	40
Female	273	Housing (emergency/transitional)	300
Male	27	Housing (permanent)	241
		Rental subsidy	33
Hispanic	68		
African American	187	Education	15
White	12	Job training/referrals	65
Asian/Pacific Islander	3	Job placement	14
Native American	-	Section 8	77
Other	30		
		Case management	275
15 and below	619	Life skills	456
16-24	80	Mental health/counseling	53
25-49	295	Transportation	224
50+	15	Food vouchers	390
		Clothing	18

Program Specific Measures		Cumulative
Number of families enrolled in project	300	300
Number of families relocated from Skid Row area within 24 hours	-	-
Number of families placed into short-term emergency housing	-	300
Number of adults who received referrals to community-based resources and services	386	420
Number of children who received intervention and services	679	850
Number of families who received monitoring/follow up after 6 months case management	353	64
Number of families no longer enrolled (termination or dropped out of program)	59	50
Number of families who received an eviction notice during the last 3 months	30	-
Number of families who lost their permanent housing during the last 3 months	6	-

Emergency Housing/Case Management	Quarter
Average length of stay in emergency housing:	-
Most frequent destination (permanent housing):	-
Case management (level 2)	
Average number of case management hours for each participant per month:	116 hours
Total case management hours for all participants during current reporting period:	348 hours
Number of cases per manager:	3 cases

Longer-term Outcomes	6 mo	12 mo
Continuing to live in housing	3	221
Obtained employment	34	
Maintained employment	55	
Enrolled in education program/school	42	
Completed high school/GED	4	
Case management	224	
Mental health	50	
Substance abuse treatment (residential)	5	
Reunited with family	176	

Additional measures to be provided after close of program:

- Gainful employment - (Number of individuals who obtained employment)
- Access to appropriate and necessary mental health or substance abuse treatment - (Number of individuals who received mental health services, Number of individuals who received substance abuse treatment)
- Educational stability for children - (Number of children)
- Socialization/recreational stability for children - (Number of children)
- Services to assist domestic violence victims - (Number who received domestic violence services/counseling)

Successes: A total of 300 families were referred by the Skid Row Assessment Team to Beyond Shelter and the Skid Row Families Demonstration Project. Beyond Shelter placed 241 of 300 participant families into permanent housing, primarily with the assistance of a Housing Authority of the City of Los Angeles (HACLA) Section 8 subsidy. The majority of these families have remained in permanent housing for at least 12 months. As of December 31, 2009, 221 families have successfully completed 12 months in permanent housing. During the current reporting quarter, seven families completed 12 months and three families completed 7 to 12 months. Only seven families have reported to Beyond Shelter that they were evicted from their apartments and have returned to homelessness. Each incidence of eviction was a result of a crisis, including mental health issues, substance abuse, or domestic violence. A total of 59 of 300 families were terminated from the program for non-compliance or loss of contact, prior to a move into permanent housing.

The current focus of the Skid Row Families Demonstration Project remains on assisting families with stabilizing in permanent housing. Presently, there are three active cases at the end of the second quarter and case managers have continued to provide specialized, individualized, and intensive support for each family. With most of the families now closed or terminated from the program, the case manager's task has been to provide support to previous clients returning for assistance with public social services, childcare referrals and community resources such as food banks. Former participants have also needed guidance regarding available resources for employment, including at least one client who Beyond Shelter was able to link with the Transitional Subsidized Employment program (TSE) through the Department of Public Social Services (DPSS). With support of their former case managers, this quarter several families were assisted with the HACLA annual recertification process. These families needed assistance to the extent that they may have lost their Section 8 vouchers without direct and specific guidance through the process.

Challenges: HACLA recently began sending notices to many successfully housed clients indicating that their Section 8 voucher will be re-issued to them for a smaller-sized unit, unless they opt to remain in their current unit and pay the higher tenant portion of rent. The higher portion of rent can increase to as much as triple the amount of rent the family is able to pay. If a family were to remain in their current unit, they would not be able to afford the rent and would certainly be evicted and, quite probably, become homeless again. Approximately 79 of the 241 families who moved to permanent housing will receive notice of a change in the formula during recertification this year and will be required to relocate. The majority of these families faced many barriers to permanent housing when they entered the Skid Row Families Demonstration Project, and will experience similar barriers to obtaining subsequent housing even if they do accept the "down-sized" Section 8 voucher. Barriers to housing that these families face include: multiple past evictions, poor credit, poor negotiating skills, and poor landlord references. Furthermore, their current landlords legally have 21 days to return their security deposits, less cleaning costs and any damages incurred beyond normal wear and tear to the apartment. Move-in costs will inevitably become a barrier to relocation. Without housing counseling or a housing relocation specialist to assist them, they will have difficulty locating property owners who accept Section 8 vouchers, and they will have a difficult time negotiating their leases.

If forced to relocate, Beyond Shelter anticipates that many of these families will be unable to utilize their Section 8 vouchers, will have them expire, and will ultimately become homeless again. These families are in need of help, but unfortunately the Skid Row Families Demonstration Project contract has ended and Beyond Shelter is not currently staffed to fully assist them with the relocation process.

Action plan: Beyond Shelter case managers operating under other government contracts are providing support to at least four former clients who have contacted Beyond Shelter regarding their HACLA voucher re-issuance. At this time, the support consists mainly of guiding them to respond to all HACLA correspondence, so that they are not automatically terminated for failure to respond. Because many of the Skid Row families are extremely dysfunctional, even the simplest steps in the Section 8 recertification process are difficult to follow; most must be provided with clear and concise guidance. Case managers have helped them understand what they are reading, and have directed them on how to respond to HACLA immediately. They have also referred clients to Legal Aid to keep them informed of the legal process. Additionally, case managers are referring families to their local L.A. City Homeless Prevention and Rapid Re-housing (HPRP) programs to determine their eligibility for homeless prevention financial assistance, which could potentially provide relocation assistance. With the help of a Housing Specialist,

however, to find landlords willing to participate in the Section 8 Program and willing to rent apartment units to families with prior evictions, poor credit, and histories of homelessness, it is anticipated that the majority of these families will lose their Section 8 vouchers and become homeless again.

Client Success Story: Client D is a 54-year-old African American male, with custody of his five-year-old grandson. His grandson's mother has been incarcerated since her son's birth, and his father was murdered. Prior to this episode of homelessness, Client D was very successful; he completed high school, took college courses in psychology, and worked over 15 years in social services. Client D and his grandson became homeless after things did not work out between him and his girlfriend, and they were asked to leave the apartment they shared. They moved from family and friends to motels, but his main concern was establishing a stable environment for his grandson. Through DPSS, they were placed in a motel but eventually that assistance was exhausted. Desperate, and living in the streets, D sought assistance in Skid Row. They were enrolled into the Skid Row Families Demonstration Project in July 2007 and were immediately placed into a motel. At the time of their arrival, the family's service needs intensity level was assessed at high intensity due to D being a single grandfather with a child under 12.

The family was soon moved into a master-leased apartment (MLA), which provided them with a stable home environment. Client D was assisted with the Section 8 Housing Choice Voucher application with HACLA and was provided tenant education. Prior to moving into permanent housing, the family's service needs were re-assessed to low intensity due to the stability they achieved while living at the MLA. Utilizing their Section 8 voucher, and with guidance from a Housing Relocation Specialist, Client D signed a lease with the property owner and converted his one-bedroom MLA to permanent housing in May 2008.

Client D's main motivation for finding permanent housing has been to provide a safe home for his grandson. The client battles with high blood pressure, kidney problems, and severe arthritis and receives regular medical treatment. Although his ailments are difficult to deal at times, the client provides his grandson with a safe and loving environment, and constant stimulating and educational activities. His grandson began school last fall and is thriving in his new environment. Beyond Shelter provided guidance and assistance with the SSI application for the client to receive state disability benefits for his medical conditions, and after approximately one year, he was approved to receive SSI benefits.

6) Multi-Disciplinary Team Serving Families
Budget: $494,000 (Ongoing Funding)

Table E.5: Multi-Disciplinary Team
FY 2009-10, through December 31, 2009

(unduplicated clients)	FY		FY
Homeless Families	174	15 and below	278
(individuals)	521	16-24	55
		25-49	175
Female	312	50+	13
Male	209		
		Housing (transitional)	23
Hispanic	132	Housing (permanent)	4
African American	375	Moving assistance	1
White	42	CalWORKs	4
Asian/Pacific Islander	6		
Native American	3	Case management	283
Other	12	Health care	106
		Mental health care	31
		Transportation	9

Case management (level 2)	
Average number of case management hours for each participant per month:	3 hours
Total case management hours for all participants during current reporting period:	1.467 hours
Number of cases per manager:	16 cases

The Skid Row Assessment Team (SRAT) originated as a result of a Board motion in December 2004. It is a collaborative between the County departments of Children and Family Services (DCFS), Public Social

Services (DPSS), Mental Health (DMH), and Public Health (DPH). On July 1, 2009 the SRAT moved into the Family Assessment Center located at the Center for Community Health Downtown Los Angeles. The SRAT is committed to attaining the goals of assuring child safety, providing ongoing case management and enforcing the zero tolerance goal for families on Skid Row. The SRAT is excited about the new opportunities that have been identified during the collaboration between County departments and the community agencies that will assist Skid Row families in the care and protection of children.

Successes: The total number of new families served by the Skid Row Assessment Team (SRAT) this quarter is 79. The total number of families relocated from Skid Row is 45. Improved collaboration between the missions, the LAHSA and the SRAT resulted in 34 of those families being placed in the month of December. During this quarter, a large number of services were provided successfully to the homeless families. Thirteen families were approved and issued Homeless Assistance through DPSS, 98 health assessments were provided through DPH, 103 clients were referred for clinical assessments through DMH, and 91 families received an assessment for child safety with DCFS with 11 of the families receiving referrals for Family Preservation or Family Support services.

Challenges: The Case Managers working with the homeless families from the SRAT and the missions continue to be faced with numerous challenges when working with the families to locate permanent housing, a transitional housing facility and/or another emergency shelter outside of the Skid Row area. The biggest challenge, the majority of families are dependent on CalWORKs for income and the availability of low-income housing and/or subsidized housing remains meager. The second biggest challenge for the team is locating vacancies for shelter and/or transitional housing within the existing Los Angeles Continuum of Care.

Action Plan: The SRAT is initiating a new pilot. Specifically, the pilot will assist the SRAT to be proactive in conducting outreach to the agencies that make up the Los Angeles Continuum of Care. Two members of the SRAT have been selected to go out in the community to various shelters and property owners across the county to advocate for placement in the transitional housing facilities as well as permanent and stable housing. The pilot will create a new opportunity to build relationships and develop new resources for the homeless families in Skid Row.

Client Success Story: The B family consists of a mother, father, six children and a grandchild. The family is from Tijuana, Mexico, but has been in California for the past 20 years. Both parents are undocumented. As reported by the family, they have no family/friend support. The mother has never worked and the father recycles goods to receive income. The family receives $694 in CalWORKs, $902 in Food Stamps, Medi-Cal and Women, Infants, and Children (WIC) assistance.

The family was referred to the Union Rescue Mission (URM) in August 2009 by 211 LACounty. The family reported this was their first episode of homelessness, and they had a temporary stay in Oklahoma while caring for their eldest daughter who is ill. Upon their arrival back to California, the family reported they found shelter by staying in a garage. In efforts to assist this family, a special family meeting was conducted (involving SRAT members, the District Homeless Case Manager (HCM), and the URM Case Manager to discuss issues regarding the best education alternative plan for the 18 year-old daughter and to determine her eligibility for DPSS financial assistance on behalf of her young child. To assist the young teen parent, the SRAT HCM contacted Roosevelt High School and spoke with the counselor to obtain school verification. In addition, the teen mother was referred to the Second Step Program at the URM for single women, which would provide her more training and support as a young mother. When the family came to the Leavey Center to inquire about the Permanent Housing Assistance through DPSS, the Eligibility Worker (EW) reviewed the case and found that the funds had been approved but were not issued to the Electronic Benefit Transaction card. The EW made the necessary contact with the District Office and the funds became available to the family within an hour. The family later applied for and received Moving Assistance. In October, the family reported they had found an apartment but experienced difficulties in renting the unit. The difficulties included language barriers, family size and the need for move-in funds. With the assistance of the SRAT and URM Case Managers, all of these barriers were overcome. While the apartment manager presented concerns about renting to this family, the supporting team members from the SRAT and URM successfully assisted the family in working with the apartment manager. As a result, the family moved into their own apartment in November 2009.

II. PROGRAMS FOR TRANSITION AGE YOUTH

7 and 8) Moving Assistance for Transition Age Youth

Goal: Assist Transition Age Youth (TAY) to move into and secure permanent housing.
Budget: $3.5 million (One-Time Funding)

Table B.1: Moving Assistance for Transition Age Youth Participants
FY 2009-10, through December 31, 2009

	Total	Probation		DCFS	
		FY	Cumulative	FY	Cumulative
Transition Age Youth	876 (100%)	53 *(new)	411	115 *(new)	**549
Female	508 (56%)	19	169	87	339
Male	378 (44%)	34	242	28	136
Hispanic	216 (24%)	11	105	24	111
African American	616 (70%)	42	290	81	326
White	36 (5%)	-	10	10	26
Asian/Pacific Islander	6 (1%)	-	6	-	-
Native American/Other	-	-	-	-	-
16-24	876 (100%)	53	443	115	475

* During the First Quarter of FY 2009-10, 62 new TAY were enrolled; 179 TAY continued to participate.
**FY 2008-09 total was 360. FY 2007-08 DCFS demographic participant data was duplicative (duplicated total 464); cumulative demographic information includes FYs 2008-09 and 2009-10.

Table B.2: Moving Assistance for Transition Age Youth Services
FY 2009-10, through December 31, 2009

(unduplicated count)	Total	Probation		DCFS	
	FY	FY	Cumulative	FY	Cumulative
Moving assistance	15	-	253	15	219
Rental subsidy	71	8	366	63	494
Housing (permanent)	88	53	364	35	269
Eviction prevention	1			1	1
Any supportive service+	-	-	101	-	64
Education	36	1	10	35	93
Job training, referrals	-	-	-	-	35
Job placement	5	5	86	-	-
Case management	83	53	411	30	464
Life skills	-	-	-	-	8
Mental health	-	-	-	-	1
Transportation	10	-	-	10	117
Food vouchers	2	-	-	2	45
Clothing	9			9	81
Auto insurance	1	-	-	1	12

+Probation does not break down supportive service by type, except for job placement.

Table B.3: Longer-term Outcomes for Transition Age Youth
(6 or more months), FY 2009-10, Second Quarter

	Probation	DCFS
Continuing to live in housing	118	102
Continuing to receive rental subsidy	-	8
Obtained employment	79	38
Maintained employment	-	70
Enrolled in educational program/school	-	63
Received high school diploma/GED	-	7

Table B.4: Program Specific Measures for Transition Age Youth
FY 2009-10, through September 30, 2009

	Probation		DCFS	
	FY	Cumulative	FY	Cumulative
Number of new approvals	53	490	85	425
Average cost per youth	$1,787	*$3,806	$3,500	*$2,663
Number of program participants satisfied with program services	173 (of 174)	248 (of 250)	20	155
Number of pregnant/parenting youth placed in permanent housing	4	94	1	72
Number exited housing	20	41	-	324
Number remaining in permanent housing and receiving assistance at 6 months	n/a	n/a	16	94

*Average cost per youth for FY 2008-09; in FY 2007-08, the average cost was $3,816 for Probation.

Probation– Moving Assistance for TAY

Successes: During the quarter, 162 youth were served, and 21 additional youth were placed in permanent housing. The program enables youth to maintain employment, get additional job training and attend college.

Challenges: There are limited vocational and educational resources available to gain marketable vocational skills while earning a salary that can financially sustain them during the training phase. The program also faces challenges in motivating youth to take full advantage of educational programs and community college opportunities to better their vocational readiness. The program's coordinator continues to assist and motivate the participants by presenting college enrollment information, including financial aid and educational grant applications.

Action Plan: Continue to offer support and motivational presentations to encourage focused career explorations and enrollment in vocational training and postsecondary educational programs.

Client Success Story: Client D is a 20-year-old male that entered the Juvenile Justice System at age 17. He completed a Camp Community Placement order and never re-offended. He is currently working for a medical billing company and has been residing in his apartment for approximately three years. Client D was able to obtain and maintain his permanent housing with the assistance of the Transition to Permanency Project. He received funding for move-in cost, rental subsidy, and appliances until he was able to become gainfully employed. When asked his thoughts regarding the HPI program, Client D stated, "I am glad that there is a program to help people at a second chance at life."

DCFS – Moving Assistance for TAY

Successes: The program continues to reduce the number of homeless youth. The program has been able to reduce the stress, fear and anxiety of homelessness on part of the participants. During this quarter, 85 youth received services, and 18 were newly approved. The program provided move-in assistance to 3 youth. The average expenditure is $30,515 per month for all new and continuing participants, which includes security deposit and rent for up to three months.

Challenges: The number one challenge continues to be difficulty in maintaining contact with the youth. There continues to be the crucial impediment of youth not taking the responsibility of getting their required documentation (paper work) in time. One other significant challenge is the downturn of the economy and the difficulties that youth are experiencing in trying to secure employment.

Action Plan: Staff will continue to encourage youth to become more stable and establish relationships with others who support stability, such as friends, relatives, former caretakers, former foster parents, etc., Staff will emphasize the importance of receiving messages, mail and other correspondence to prevent homelessness.

Client Success Story: A 21-year-old female, former foster youth, facing eviction was near completion of her Pharmacy Tech School program. DCFS provided rental assistance to prevent her from being homeless, while she worked to complete her education. This youth continues to be focused on improving and stabilizing her life. Additionally, she has learned the importance of prioritizing her life.

III. PROGRAMS FOR INDIVIDUALS

9) Access to Housing for Health (AHH)

Goal: To provide clients discharged from hospitals with case management, housing location and supportive services while permanent housing applications are processed.
Budget: $3 million (Board Approved Funding)

Table C.1 : Access to Housing for Health Participants and Services
FY 2009-10, through December 31, 2009

(unduplicated count)	FY	Cumulative
Homeless Individuals	13	27
Chronic Homeless	13	102
Homeless Families	2	6
Female	15	59
Male	16	86
Transgender	-	1
Hispanic	5	32
African American	15	64
White	10	47
Asian/Pacific Islander	-	1
Native American	-	-
Other	1	2
15 and below	2	9
25-49	9	51
50+	20	86
Moving assistance	16	69
Housing (emergency/transitional)	28	135
Housing (permanent)	22	84
Rental subsidy	22	84
Eviction prevention	6	4

	FY	Cumulative
Education	3	5
Job training	4	5
Job placement	-	2
General Relief and Food Stamps	2	2
General Relief	1	62
Food Stamps only	-	1
Medi-Cal/Medicare	8	37
Section 8	20	48
Public Housing Certificate	6	16
SSI/SSDI	9	32
	FY	**Cumulative**
Case management	28	135
Health care	28	135
Life skills	28	135
Mental health/counseling	5	33
Substance abuse (outpatient)	1	17
Transportation	6	103
Alternative court	1	1

Program Specific Measures	FY	Cumulative
Number of referrals	105	708
Number admitted to program (enrolled)	28	135
Pending applications (quarter)	5	n/a
Number that did not meet eligibility criteria	84	578
Number of exited clients	4	33
Reduction in Emergency Department visits (12 months post enrollment, n=59)	-	83%
Reduction in number of inpatient days (12 months post enrollment, n=59)	-	90%
Number of new AHH enrollees that have a primary healthcare provider	28	135

Transitional Housing/Case Management	
Average stay at emergency/transitional housing:	144 days
Case management (level 3)	
Average case management hours for each participant per month:	15 hours
Total case management hours for all participants during current reporting period:	825 hours
Number of cases per case manager:	11 cases

Table C.2: Longer-term Outcomes
FY 2009-10, Second Quarter

	6 mo.	12 mo.
Continuing to live in housing	59/61	47/49
Receiving rental subsidy	97%	96%
Case management	9	2
Health care	9	6
Mental health care	4	1
Substance abuse treatment (outpatient)	1	4
Reunited with family	-	1

Successes: To date, there are 59 AHH clients that have reached their one year mark in the program. They had a combined total of 255 Department of Health Services (DHS) Emergency Department visits during the 12 months prior to AHH enrollment. Post enrollment, the clients had a combined total of 46 DHS Emergency Department visits. **The number of DHS Emergency Department visits was reduced by 83%.** The 59 AHH clients also had a combined total of 487 DHS inpatient days prior to AHH enrollment. These clients had a combined total of 45 DHS inpatient days post AHH enrollment. **The number of DHS inpatient days was reduced by 90%.**

AHH clients and graduates continue to participate in the monthly meetings which offer resources, health education and community/social supports. The Thanksgiving Day and Holiday Celebrations in November and December were highly attended and client's thoroughly enjoyed Dr. Diamant's presentation and the festivities. AHH continues to offer a weekly support group which many clients attend. This group allows them to meet other program participants, share resources and gain support. Lastly, AHH implemented a new weekly therapy group focusing on relationships to assist clients in exploring their past and current relationships and to maintain and obtain healthy relationships.

Challenges: There continues to be challenges in obtaining appropriate referrals for clients that would be suitable for the AHH program. Many do not pass the Housing Authority criminal background. Others do not possess the skills necessary for independent living and/or require a higher level of care than AHH can provide. These clients present with severe physical and/or psychiatric conditions and are unwilling to access treatment or comply with medication. AHH serves a particularly vulnerable population. Two clients exited the program this quarter for the following reasons: one client passed away and one client was transferred to a Board and Care Facility. In addition to the referrals, there continues to be challenges in obtaining all necessary and current documentation in a timely manner from clients in order to submit complete applications to the Housing Authorities.

Action Plan: The DHS Project Coordinator continues to receive referrals, and the referrals are being processed by Homeless Healthcare Los Angeles in a timely manner. The AHH team remains fully staffed. The AHH Housing Locator continues to assist in ensuring the housing application; location and move-in process are meeting the client's needs and occurring in a timely manner. The case managers and housing locator continue to work closely to best assist clients and ensure that they obtain and maintain permanent housing. The AHH staff continues to promote the program with current referral sources and to develop new sources.

Client Success Stories: Ms. H is a 47-year-old African American female who was in an abusive relationship for five years. She became homeless as a result of leaving her abuser. She was homeless for three months before entering the AHH program. Ms. H is a single woman with no children. Following two hospitalizations at Los Angeles County (LAC+USC) in 2008, she was referred to AHH and enrolled in November 2008. She has a history of Hypertension, Coronary Heart Disease, Type II Diabetes (insulin dependent), and was diagnosed with schizophrenia in 2003.

After working as a care giver for In Home Supportive Services (IHSS) for seven years, she stopped working in 2004 due to her medical conditions. The client currently receives SSI/Medi-Cal. Ms. H was permanently housed by AHH in June 2009; however, the apartment complex went into foreclosure shortly thereafter. AHH's housing locator and case manager worked together to assist the client in relocating to another apartment that would accept a Housing Authority of the City of Los Angeles (HACLA) Section 8 voucher. As a result, Ms. H moved into a new apartment in September 2009. The client is accessing mental treatment and receives medical treatment through a private physician (paid for by Medi-Cal). The AHH program assisted Ms. H with keeping her medical appointments and ensuring that she continues to access mental health treatment. Upon starting the AHH Program Ms. H's affect was dysphoric and flat.

During her time with AHH her mood dramatically elevated and her social skills improved. Since she has been permanently housed, she has reunited with friends and family. Ms. H has siblings in Los Angeles and a sister in New Mexico that she has close relationships. She has also befriended some of the other AHH clients and has held social gatherings in her new home. The client has been successful in her housing for seven months and continues to attend the AHH monthly meetings. Although her medical conditions continue to deteriorate, she is better able to focus on her medical needs and access treatment.

10) Benefits Entitlement Services Team for the Homeless (B.E.S.T.)
Budget: $2,000,000 (One-Time Funding)

Table C.3: B.E.S.T Services
FY 2009-10, Second Quarter

(unduplicated clients)	Quarter		Quarter
Homeless Individuals	5	Housing (emergency)	13
Chronic Homeless	77	Housing (transitional)	3
		Housing (permanent)	1
Female	22		
Male	60	General Relief and Food Stamps	3
		Section 8	1
Hispanic	12	SSI	1
African American	52	Transportation	1
White	11		
Asian/Pacific Islander	2	Case management	82
Native American		Health care	13
Other	5	Mental health care	69
16-24	3	Case management (level 3)	
25-49	46	Average hours for each participant	8
50+	33	Total hours for all cases	656
		Average caseload per case manager	15
Program Specific Measures			
Number of initial applications submitted to SSA			5
Number of initial applications approved by SSA			1
Average length of time from participant enrollment date to SSA approval date			28

Successes: The Benefits Entitlement Services Team for the Homeless (B.E.S.T.) started enrolling participants on December 1, 2009. By the end of December, there were already 82 participants assessed and enrolled into the program. Of the 82 participants, five had enough medical records to submit an online application to the Social Security Administration (SSA). Information about the approval of one of those applications was received in December 2009 - the same month the project started.

Challenges: There are inherent challenges to get a demonstration project up and running. One of the primary challenges of this program was filling all of the open positions to build a team. Especially challenging was getting the case management staff in place that worked in unison with JWCH's project manager. As with any collaboration, the contractor (JWCH) and subcontractor (VOA) had to get to know each other and make their relationship work within the parameters of the contract and statement of work. Challenges are being looked at carefully so the team can learn valuable lessons for the future of this project.

Action Plan: No action plan is necessary at this time.

Client Success Story: A 38-year-old African American female was assessed and enrolled in the B.E.S.T. program in early December 2009. At enrollment in B.E.S.T., this participant was in a wheelchair and living in a mission in Skid Row. Further, she had been homeless for over 10 years and did not have any source of income at the time of enrollment. The participant qualified for SSI due to multiple physical disabilities (rheumatoid arthritis and degenerative joint disease) and has not been able to work for many years. The participant's SSI benefits were approved at the end of December 2009 by the Social Security Administration.

Currently, the participant has been reunited with her brother and is living with him. JWCH staff is also assisting the participant to obtain a new wheelchair since her old one is no longer functional, therefore rendering her homebound. B.E.S.T. case management staff has also applied for permanent housing at ACOF for this participant. She is the first participant in the B.E.S.T. for the Homeless demonstration project to receive her benefits.

11) Center for Community Health Downtown Los Angeles
Budget: $186,000; ($76,000 expected for Ongoing Funding)

Table C.4: Center for Community Health Downtown Los Angeles (CCH)
FY 2009-10 through December 31, 2009

(unduplicated clients)	FY		FY
Homeless Individuals	3,744	Moving assistance	1
		Housing (emergency)	33
Female	986	Housing (transitional), average stay 90 days	25
Male	2,758	Housing (permanent)	53
		Rental subsidy	1
Hispanic	827		
African American	1,921	General Relief and Food Stamps	10
White	410	Medi-Cal/Medicare	12
Asian/Pacific Islander	55	Section 8	8
Native American	11	SSI/SSDI	12
Other	1,347		
More than one race/ethnicity may be selected		Case management	299
		Health care	3,588
16-24	122	Mental health care	415
25-49	1,835	Recuperative care	1
50+	1,787	Substance abuse treatment (outpatient)	11
		Transportation	12
Case management (level 3)		Other	25
Average number of hours:	256		
Total case management hours:	768	Job training/referrals	18
Number of cases per manager:	95	Education	1

Successes: The Center for Community Health Patient Satisfaction Survey results for the past quarter were the best ever by a JWCH Clinic. Patients were especially happy with the quality of services provided and the increased ability to access services in a timely manner. The new facility was also a key contributing factor, as evidenced in the patient comment section. Ninety-seven percent of patients surveyed said the likelihood of referring their friends was great or good. Case conferencing has improved since the last report was submitted. There are more patients receiving an Individualized Service Plan and a multidisciplinary approach to care. A total of 53 patients have been placed into permanent supportive housing, and 299 patients are being intensively case managed. Dental services are now available on Fridays with staffing by the University of Southern California (USC) School of Dentistry.

Challenges: Substance abuse assessment and counseling has been a key challenge during the first six months. Referrals have been much less than expected. The data report being submitted shows that only two patients enrolled in an outpatient program, and only one was placed in a residential treatment program.

Action Plan:
The problem with Substance Abuse integration and utilization is being addressed and the providers have suggested that a greater emphasis on counseling rather than assessment and referral to services would be a better approach. Many patients are unwilling to commit to a program, but would benefit from ongoing counseling and motivational interviewing while they are in the pre-contemplative or contemplative stage. A CCH Clinical Services meeting on February 8th included a presentation by Homeless Healthcare Los Angeles (HHCLA) followed by a discussion of possible strategies for improvement.

Client Success Story: A 26-year-old male initially presented to the CCH requesting TB clearance for entry to a local shelter. The treating physician requested a same day evaluation for the patient for assistance with housing placement and other social services (patient was homeless, with poor hygiene and poor communication skills). The patient had recently moved to California four months prior to his visit to CCH. He was originally from St. Louis and had lost his job as an assistant to a traveling salesman in August. The patient stated he would like to return to St. Louis, but did not have any money or a way to get there. He had been on SSI in St. Louis due to brain damage that occurred from a childhood accident (the patient fell from a window in a burning house when he was four years old and spent four years in a coma). The

patient had been estranged from his family for four years after an argument he had with his stepfather. He had been living with his mother at the time, who he claimed was taking advantage of him for his money. The patient had lost all contact information relating to his family.

The MSW referred the patient to the Benefits Entitlement Service Team (BEST) for assistance with obtaining government benefits, and verification of previous enrollment. The BEST was able to confirm his previous enrollment in the SSI Program and he was connected to a Case Manager with the Program. The Case Manager worked with the patient to locate one of his siblings from information obtained on the Internet. The sibling and other relatives who were subsequently located had all thought the patient was dead after he was reported missing four years ago. All in tears and excited to reconnect with their lost brother, family members were able to clarify what was said during that ill-fated argument four years ago. After a successful case conference between the client and his mother (set up by the Case Manager and MSW), it was agreed that the patient would go back to St. Louis to reunite with his family. The patient was extremely happy about going home. The MSW subsequently assisted the patient in obtaining funds for his return home through a Travelers' Aid Program that sponsored a bus ticket for that same evening. The patient was escorted to the Greyhound Bus Station in Hollywood, and he arrived safely in St. Louis two days later. The MSW had contacted the patient's mother regarding his travel, and she was at the station in St. Louis to meet him when he arrived. His mother called the MSW to confirm his arrival and express the family's excitement over the reunification that occurred.

12) Co-Occurring Disorders Court

Goal: Assist dually diagnosed adult defendants in receiving comprehensive community-based mental health and substance abuse treatment.
Budget: $200,000 (HPI On-going Funding; pass through for DMH)

Table C.5: Co-Occurring Disorders Court Participants and Services
FY 2009-10, through December 31, 2009

(unduplicated count)	FY	Cumulative		FY	Cumulative
Chronic Homeless	18	84	Education	-	15
Homeless Individuals	9	14	Job training/referrals	6	32
Transition Age Youth	3	4	Job placement	3	4
Female	17	59	CalWORKs	1	2
Male	13	44	General Relief (GR,FS)	3	17
			General Relief	2	2
Hispanic	3	11	Food Stamps only	1	4
African American	21	78	Medi-Cal/Medicare	-	32
White	5	10	SSI/SSDI	5	35
Asian/Pacific Islander	1	1	Shelter Plus Care	-	5
Other	-	2			
16-24		7	Alternative court	24	69
25-49		61	Case management	24	69
50+		34	Health care/medical	24	47
			Life skills	24	65
Eviction prevention	-	2	Mental health/counseling	24	69
Housing (emergency)	-	8	Social/community activity	18	38
Housing (transitional); avg. 210 days	6	53	Substance abuse (outpatient)	8	71
Housing (permanent)	5	7	Substance abuse (residential)	27	45
Rental subsidy	9	42	Transportation	24	69
Moving assistance	-	2	Clothing/hygiene	23	45
Longer-term Outcomes (six or more months)					
Continuing to live in housing					37
Receiving rental subsidy					16
Enrolled in educational program, school					4
Obtained/maintained employment					8
Case management					30
Health care					30
Good or improved physical health					27

Mental health/counseling	30
Good or improved mental health	22
Substance abuse treatment (residential)	8
No drug use	7
Emergency Housing/Case Management	
Case management (level 3)	6 hours
Total case management hours for all participants during current reporting period:	970 hours
Number of cases per case manager:	7 cases

Successes: Since the inception of the CODC program in April 2007, 12 clients have graduated from the program. All received a dismissal of the criminal charges that initiated their referral to the CODC program. Another four clients are expected to graduate in the third quarter of FY 2009-10.

The CODC treatment program at the Antelope Valley Rehabilitation Center (AVRC) in Acton continues to serve as an appropriate starting point for those clients being released from detention facilities. To date, 37 clients have received integrated co-occurring disorders therapy, case management, and medications management at AVRC. Fifteen of these clients have successfully completed the 90-day program and have transitioned into programs in the community, such as the Mt. Carmel sober living program, for continued treatment and supervision. The implementation of the "Step Up Program" at Mt. Carmel, which offers clients a high level of structure and treatment services, has contributed to a decrease in program attrition.

Currently, there are four full-time Consumer Employees working at SSG Central Mental Health. These consumers are highly regarded by their peers and take pride in helping others. New CODC clients in particular appreciate receiving services from individuals who have shared similar experiences and have turned their lives around. They reported feeling more connected, better understood, and now have inspiring role models to emulate. A new Employment Specialist, funded by a Department of Justice grant, joined the SSG Team in February 2010. The Employment Specialist promotes linkages to education, job training, employment, and volunteer opportunities.

DMH continues to partner with the Public Defender to identify suitable candidates for the CODC program. Since the inception of the CODC program in April 2007 through December 31, 2009, DMH staff screened 616 individuals. A total of 173 clients received observation and engagement services and/or were enrolled for CODC treatment services. The Public Defender has been the primary source for referrals, generating nearly 81% of the referrals received during FY 2009-10 thus far. Referrals were also received from the Bench Officers, District Attorneys, Alternate Public Defender, bar panel attorneys, and the DMH Jail Linkage program.

Table C.6: Program Specific Measures	FY	Cumulative
Number of clients screened for enrollment	115	519
Number of clients accepted for observation	32	110
Total number of clients enrolled	21	87
Number of clients pending enrollment	15	30
Number of clients not meeting Program criteria	64	254
Number of clients rejecting/dropping out prior to enrollment	21	120
Number of clients lost during follow-up process	-	6
Number of participants in ER/crisis stabilization while enrolled in program	9	30
Average length of hospital stay (days)	3	17
Number of participants who have a primary healthcare provider while enrolled	22	75
Number of participants with new arrest(s)	9	30
Misdemeanor:	3	6
Felony:	6	20
Number of participants in jail	9	31
Average number of days in jail.	15	(FY 08-09) 25

FY 2007-08 average number of days in jail: 36

Challenges: While treatment at AVRC continues to be well-received by a majority of the CODC clients, the AVRC treatment schedule continues to be limited, resulting in extended periods of "down time." Last quarter, the management team at AVRC initiated plans to adopt the Matrix System of Care to enhance the daily activity schedule and increase the amount of treatment and service provision for each client.

However, the Matrix System of Care has yet to be implemented. This has resulted in some of the clients verbalizing their feelings of frustration at the minimal amount of activities and structure. Others have found it difficult to transition from the semi-structured treatment environment at AVRC to the highly-structured program at Mt. Carmel.

Action Plan: Energy continues to be focused on grant writing to access new funds to enhance existing services. DMH continues to collaborate closely with the Public Defender, the Sheriff, and other court personnel to identify prospective CODC clients. In addition, DMH Administration has been working with SSG to evaluate the feasibility of increasing capacity for serving additional CODC clients.

Client Success Story (by client):
"I was homeless for two years when I was arrested for cocaine possession. When I went to court, I took a program called Prop 36. They sent me to SSG. I learned how to be a lot more responsible. It was very hard for me at first. But SSG helped me and showed me how to get back on track. There were a lot of times when I felt like leaving the program and almost did! I stayed because of support from the other people in the program, my sponsor Tim, my substance abuse counselor Bob, my case worker Miriam, and the rest of the staff here at SSG and Prop 36. I thank the "system" and SSG for all their help. Thank you."

The client graduated from the CODC Program in February 2010.

13) DPSS General Relief (GR) Housing (Rental) Subsidy and Case Management Project

Goal: To assist the homeless GR population with a rental subsidy. In addition, coordinate access to supportive services and increase employment and benefits to reduce homelessness.

Budget: $4.052 million (HPI On-going Funding)

Table C.7: DPSS GR Housing Subsidy and Case Management Project Measures
FYs 2008-09 and 2009-10, through December 31, 2009

			Cumulative
Chronic Homeless	665	Education	27
Homeless Individuals	1,781	Job training/referrals	756
		Job placement	231
Female	953		
Male	1,493		
		SSI/SSDI	224
Hispanic	297	Section 8	5
African American	1,616	Veteran's	1
White	457		
Asian/Pacific Islander	40		
Native American	18	Case management	3,040
Other	18	Health care	857
		Life skills	448
16-24	272	Mental health/counseling	774
25-49	1,656	Substance abuse (resident)	21
50+	518	Substance abuse (outpatient)	135
	Cumulative	Transportation	945
Rental (housing) subsidy*	3,040	Recuperative care	3
Moving assistance	2,294	Social/community event	1

Longer-term Outcomes (point in time)	**6 mo.**	**12 mo.**	**18 mo.**
Receiving rental subsidy	476	216	197
Obtained employment	14	-	-
Maintained employment	6	-	-
Enrolled in educational program, school	5	-	-
Case management	476	216	197
Health care	38	19	18
Mental health/counseling	18	34	21
Substance abuse treatment (outpatient)	4	2	1

**Total number served from July 2006- December 2009*

Table C.8: DPSS GR Housing Subsidy and Case Management Project Measures FY 2009-10, Second Quarter		
	Second Quarter	**To date**
Number of applications received	593	2,412
Average number of business days to approve	19	19
Average amount of rental subsidy	$292	$292
Number of individuals re-entering program	37	140
Number of SSI approvals	72	212
Percent of SSI approvals	4.35%	(FY 2008-09) 7.94%
Number of individuals disengaged from program	239	895
Case Management (level 3)		
Average case management hours for each participant per month:		5 hours
Total case management hours for all participants during current reporting period:		4,793 hours
Number of cases per case manager:		96 cases

Successes: The number of active subsidies for the last month of the quarter was 891, which is nine short of the maximum allotment. During this quarter, there were 35 job placements and 72 SSI approvals. An evaluation study of the pilot's outcomes showed that the average length of stay for participants in the pilot program was about seven months. Compared to a control group, employable participants enrolled in the pilot project were two times more likely to find jobs.

Challenges: Participants were relocating or moving out of their rental units without notifying the case-carrying Eligibility Worker or the GR Housing Case Manager, and their rental subsidies are issued to their previous landlords which created more work for staff recouping the money from landlords and processing the documentation from the new landlord in a timely manner.

Action Plan: The following were the recommended action plans:

- Staff to explain and remind the participants of their reporting responsibilities;
- Encourage participants to provide valid contact numbers; and
- Staff to increase the frequency of contacts with participants to a minimum of twice a week.

Client Success Stories:

Mr. O was a Food Stamp participant since 2005, then in August 2008 his health deteriorated and he had to apply for GR. At the time, Mr. O became homeless and was referred to the GR Housing Subsidy Project and moved into his new home in October 2009. Mr. O religiously kept his medical appointments, including assessment and treatment services. Mr. O was approved for SSI benefits and received his first SSI check this quarter. He is very grateful to DPSS.

Mr. J was diagnosed with mental health problems since childhood. Mr. J refused treatment because the medication made him feel bad. After encouragement from the Housing Case Manager (HCM), he gradually went for treatment and took his medication. Mr. J was relocated to a place where he had his own room, but shared common space with other residents. Despite Mr. J's situation, with the help of his SSI Advocate and HCM, he was approved for SSI.

14 and 15) Homeless Release Projects (DPSS-DHS and DPSS-Sheriff)

Goal: Identify individuals scheduled for release who are eligible for DPSS administered benefits.
Budget: DPSS-DHS: $588,000; DPSS-Sheriff: $1.171 million (On-going Funding)

Table C.9 Homeless Release (unduplicated count) FY 2009-10, through December 31, 2009	Total FY	DPSS-DHS FY	DPSS-DHS Cumulative	DPSS-Sheriff FY	DPSS-Sheriff Cumulative
Homeless Individuals	1,196	137	*965	1,059	*5,254
Female	376	31	120	345	1,089
Male	714	106	431	714	1,368
Transgender		-	-	-	5
Hispanic	403	40	163	363	906
African American	459	42	206	417	1,129
White	264	40	147	224	540
Asian/Pacific Islander	44	9	17	35	40
Native American	5	2	4	3	6
Other	24	4	14	20	42
16-24	221	5	23	216	494
25-49	784	77	297	707	1,619
50+	194	55	231	139	349
Housing (emergency)	74	30	105	44	262
Average stay (days)	24	13	-	11	-
CalWORKs (approvals)	7	1	2	7	57
General Relief (w/FS)	445	52	342	393	2,595
General Relief only	84	15	92	69	372
Food Stamps only	8	-	5	8	57
SSI/SSDI	31	-	-	31	56
Veterans' benefits	7	-	-	7	13

*Demographic information not available for FY 2007-08. Cumulative demographic information includes FYs 2008-09 and 2009-10.

Table C.10 Program Measures	Cumulative Total	DPSS-DHS FY	DPSS-DHS Cumulative	DPSS-Sheriff FY	DPSS-Sheriff Cumulative
Total referrals received	10,221	190	1,002	1,343	9,219
Total referrals accepted	6,757 (66%)	70	494	1,062	6,263
Of the total referrals accepted:					
Total approved	545 (FY)	68	*201	477	3,123
Total denied	21 (FY)	-	*186	21	154
Total pending release:	1,725 (QTR)	2	-	1,725	-
Releases/discharges	1,047	65	304	610	743
Number of applications					
Food Stamps	286	42	43	194	243
General Relief	3,033	26	401	275	2,632
CalWORKs	49	-	1	4	48

**Information not available for FY 2007-08.*

DPSS-DHS Homeless Release Project

Challenges: The private hospitals continued to have an extremely low number of referrals and only two approvals since implementation.

Action Plan: Program staff has offered training to assist the private hospital staff on the use of the DPSS screening tool and has met to discuss ways to increase referrals.

DPSS-Sheriff Homeless Release Project

Successes: Priority list interviews done at Inmate Reception Center (IRC) rather than at Men's Central Jail attorney room has increase significantly. The priority list allows the Eligibility Worker (EW) to interview more inmates in less time.

Challenges: Referrals were drastically reduced in the second quarter.

Action Plan: Contact was made with the CDRF Community Transition Unit (CTU) staff to determine the reason for the reduction. Within two working days, the number of referrals significantly increased.

16) Homeless Recuperative Care Beds

Goal: Provide recuperative care services to homeless individuals being discharged from County hospitals and assist participants with accessing transitional or permanent housing, ongoing health care, and other resources and supportive services.
Budget: $2.489 million (One-Time Funding)

Table C.11 : Homeless Recuperative Care Beds Participants and Services
FY 2009-10, through December 31, 2009

(unduplicated count)	FY	Cumulative		FY	Cumulative
Homeless Individuals	144	424	Housing (permanent)	19	64
			Housing (transitional)	36	108
Female	25	68	Housing (emergency)	5	44
Male	119	354			
Transgender	-	2	General Relief only	-	11
			Medi-Cal/Medicare	-	7
Hispanic	61	107	SSI/SSDI	-	7
African American	38	106			
White	36	86	Case management	144	424
Asian/Pacific Islander	3	5	Health care	144	424
Native American	2	2	Life skills	-	12
Other	4	21	Mental health/counseling	-	1
(race doesn't include two quarters; updating)			Recuperative care	144	424
16-24	-	4	Transportation*	-	70
25-49	73	212	Substance abuse (outpatient)*		
50+	71	208			

Program Measures	FY	Cumulative
Number of patients referred for recuperative care beds	176	532
Number of patients admitted to recuperative care services	144	424
Number of patients who were discharged from recuperative care services	117	395
Number of patients who were assigned to a primary health care provider during recuperative care stay	103	383
Average length of stay for patients in recuperative care program (days)	23	30
Percent decrease in ER visits 6 months after receiving recuperative care	-	30%
Percent decrease in inpatient admissions 6 months after receiving recuperative care	-	71%

Emergency Housing/Case Management	
Average stay at emergency/transitional housing:	23 days
Level 3 Assisted/Supported Referral and Counseling case management services	
Average case management hours for each participant per month:	6 hours
Total case management hours for all participants during current reporting period:	480 hours
Number of cases per case manager:	25 cases

Successes: The Recuperative Care program **served 424 unduplicated individuals** to date, from April 2008 to December 2009. At the end of the last quarter, a six-month pre- and post- analysis was conducted on the participants served who received recuperative care services at least six months prior to the analysis. For these recuperative care participants, a pre-post comparison showed a **30% reduction in ER visits and a 71% reduction in inpatient hospitalizations.** In addition, there was a **47% decrease in the number of participants who utilized the ER and a 73% decrease in the number of participants who required hospitalization**.

Challenges: The most significant challenge continued to be the lack of available and appropriate housing after discharge from recuperative care. Additionally, JWCH Institute (the provider) reported that private funding for 10 of their transitional beds ended in this quarter. Such losses in accessible housing/placement resources significantly impacts efforts to discharge recuperative care clients into more stable housing environments. Some clients were not able to access housing resources that have requirements on an applicant's behavioral history or restrictions related to legal status which present additional challenges. Other various challenges continued to be data collection and reporting activities, particularly given the use of manual data collection and reporting methods.

Action Plan: Additional efforts in assisting clients to reconnect with their families are being made, including family members that live outside of the Los Angeles County area. Efforts to link recuperative care services with permanent housing opportunities are continuing. Eligible participants who are frequent users of DHS inpatient and/or ER services have been referred into to the Access to Housing for Healthcare program with some success. The recuperative care director at JWCH has oversight responsibilities for program activities and is continuing to work on addressing the identified challenges, including development of a database/data collection system for these services. DHS staff will continue to meet with JWCH management staff to discuss program status and progress and provide assistance as needed. Although some improvements have been noted for data collection and reporting activities, further improvement is needed and DHS will continue to work with the program director.

Client Success Story: Client B is a 51-year-old African-American male who was referred to the Recuperative Care Program by LAC+USC Medical Center in September 2009. He presented to LAC+USC with diagnoses of blunt head trauma and multiple facial fractures, status post assault, with loss of consciousness. Prior to his hospital admission, he and his girlfriend of nine years were living in their truck, since losing their apartment two years ago. Upon entering the Recuperative Care program with JWCH, the client had swelling over the right orbital area and three simple sutures to his right cheek. The client also had a history of hypertension, which the nurses were monitoring on a daily basis. The case manager focused on obtaining vital services for B as soon as he entered the program. First, B needed an ID, for which JWCH supplied a reduced-fee DMV voucher. The case manager also arranged for a Paratransit pass, so that B could easily travel to his arranged referrals and appointments. In B's case, this was important because it was necessary for him to attend meetings for his substance abuse problem, which was an essential part of his care plan. Additionally, B was started on a hypertensive medication, which was provided by JWCH clinic, located nearby at the Center for Community Health (CCH). Into his third week at Recuperative Care, the provider noted his blood pressure remained high. His medication dosage was increased and further monitored throughout the duration of his stay. Last November, B continued to be followed up by the Recuperative Care provider and it was shown that the client's hypertension was controlled. He kept all his follow-up visits at LAC+USC Medical Center and used the JWCH free net van for transportation.

While B was in Recuperative Care, his girlfriend S gained entrance to Project Paycheck, another program located at the Weingart Center. As she regularly visited B to check on his health and well-being. The couple was determined to remain together even throughout their hardships. They were married in October 2009, while they were both still staying at the Weingart. Although his wife was involved in another program, the Recuperative Care case manager assisted the couple to apply for the Access to Housing for Health (AHH) permanent housing program. They were accepted into the AHH program and the prospect of resuming a normal life together overwhelmed them with joy and a ton of emotion! From the first day in the Recuperative Care program to his discharge in November, B benefited strived to fully benefit from the program services. He diligently followed the recommendations made by the case manager and the medical staff. At the time of discharge, his facial area was no longer swollen and he no longer had complaints of dizziness or pain. He left the program highly knowledgeable about his condition and the importance of controlling his hypertension. The Recuperative Care staff are confident that he will continue his medical treatment and maintain his follow-up appointments at the CCH. At last news, B was actively seeking full-time employment, and very optimistic that he would secure a job shortly. The JWCH staff are cheering and hoping for the best for both!

17) Housing Specialists - DMH

Goal: Assist homeless individuals, families, and transition age youth (TAY) to obtain and maintain permanent housing.

Budget: $923,000 (annually in MHSA funding)

Table C.12: Housing Specialists Program Specific Measures
FY 2008-09

	FY 2009-10	FY 2008-09	FY 2007-08
Number of referrals to program	n/a	842	n/a
Number of property owners contacted	776	360 (QTR)	898

Successes: During the second quarter, the Countywide Housing Specialists, funded through the Mental Health Service Act (MHSA), initiated contacts with 328 unduplicated homeless individuals and 16 homeless families with a mental illness. Based on these contacts, the Housing Specialists provided a variety of housing related services including the following: 86 individuals received assistance to find permanent housing; 145 were referred to an emergency shelter funded through the Department of Mental Health (DMH); 37 moved into transitional housing program; and 13 received financial assistance with their moving-in expenses (security deposits). As of December 31, 2009, DMH completely utilized funds in the amount of $51,051 secured through the American Recovery and Reinvestment Act (ARRA) Emergency Food and Shelter Program (EFSP) to supplement the existing Countywide Housing Assistance Program funded through the MHSA and the Projects for Assistance in Transition from Homelessness (PATH) grant. DMH also applied through the EFSP funding for $80,000 in motel vouchers and $80,000 in food vouchers. Although these resources would be granted through EFSP, these are not ARRA funds, therefore, the funds would be available Countywide through the department's directly-operated clinics.

Table C.13: Participants and Services
FY 2009-10, through December 31, 2009

	FYs 2008-09 and 2009-10	FY 2007-08
Chronic homeless individuals	79	-
Homeless individuals	1,440	2,343
Homeless families	120	255
Transition age youth	16	142
Demographics not provided for all participants in families		
Female	874	*n/a
Male	772	
Transgender	10	
Hispanic	618	
African American	472	
White	403	
Asian/Pacific Islander	39	
Native American	15	
Other	65	
15 and below	3	
16-24	10	
25-49	1,556	
50+	30	
	FY 2009-10	**Cumulative**
Moving assistance	162	304
Eviction prevention	19	24
Housing (emergency)	955	1,762
Housing (transitional)	375	678
Housing (permanent)	394	711
Rental subsidy	132	236
Section 8	210	*210
Shelter Plus Care	2	2
Mental health	681	*681
Life skills	327	327
Residential management	395	395

*Information not available for FY 2007-08.

Challenges: The Department continues to be challenged with assisting the target population to identify affordable permanent housing. DMH relies on rental subsidies provided through contracts with the Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the County of Los Angeles (HACoLA) to access private rental housing. Currently, the Department has very limited Federal housing subsidies available for DMH clients through the Shelter Plus Care and none through the local Homeless Section 8 Programs offered by both HACLA and HACoLA. DMH competed for additional rental subsidies with the local housing authorities and was awarded but currently awaits the execution of those contracts.

Action Plan: The Department will continue to work towards finding ways to identify affordable permanent housing to meet the housing needs of the low and very low income population DMH serves. The Department will continue to apply for rental subsidies offered by the local housing authorities; seek other funding sources for rental subsidies; and disseminate information regarding the availability of affordable housing projects that target individuals with low income. In addition, DMH through the MHSA Housing Program has committed funds for Capital Development and Capitalized Operating Subsidies to 29 local housing projects thereby creating a pipeline of approximately 800 new affordable housing units in Los Angeles County.

Client Success Story: A 50-year-old homeless female from West Central Clinic in Service Area 6 was homeless for over 16 months and became dependent on crack cocaine. The West Central Clinic Housing Specialist outreached to this woman. She was referred to the American Philanthropic Association Shelter where she stayed for 10 months. While she was housed in the shelter, she attended substance abuse groups and became drug free. She joined the "Home of my own" group at West Central Clinic and entered the Housing Program where she was assisted in applying for a Shelter Plus Care subsidy. In the meantime she continued to take steps towards her recovery by attending money management classes where she learned budgeting and other independent living skills. She was approved for Shelter Plus Care and was assisted in finding a one-bedroom apartment. As a result of securing permanent housing, she was granted custody of her 11-year-old child who had been placed in the foster care system. At present she is in the process of getting a two-bedroom apartment to properly accommodate her child. She has since restored the lost relationship with her mother and two grown children.

18) Just In-Reach Program

Goal: Engage homeless nonviolent inmates upon entry into jail. Develop a release plan that coordinates an assessment and links clients to supportive services, benefits, and housing options upon their release. Case management team works with clients to obtain employment and explore rental subsidy eligibility.
Budget: $1,500,000 (One-Time Funding)

Table C.14 : Just In-Reach Program
FY 2009-10, through December 31, 2009

	Cumulative		Cumulative
Homeless Individuals	221	Housing (emergency)	13
Chronic Homeless	314	Housing (transitional)	133
		Housing (permanent)	77
Female	161	Moving assistance	32
Male	303	Rental subsidy	4
Hispanic	128	Life skills	24
African American	209	General Relief (and Food Stamps)	67
White	162	General Relief only	63
Asian/Pacific Islander	12	Food stamps only	38
Native American	3	SSI/SSDI	20
Other	49	Veterans' benefits	18
(not for all participants)		Case management	410
		Health care	22
16-24	88	Mental health care	21
25-49	501	Substance abuse, outpatient	45
50+	96	Substance abuse, residential	71
		Transportation	107
Job training	392	Legal advocacy	135
Job placement	42		
Education	70		

Program Specific Measures	Cumulative
Number of participants who received intake/enrollment	532
Number of participants who received intake/enrollment within 72 hrs of initial interview	362
Number of participants who did not complete program (exited prior to completing)	130
Number by violent crime	139
Number by non-violent crime	395

Number by area of residence prior to incarceration (most frequent residence)	370
Number by area of residence prior to incarceration (second most frequent residence)	60
Number of times in County jail	682
Number of times in State prison	115
Number of participants with a service plan	1,982
Number of participants with a service plan within a week from intake/enrollment	1,954
Number of referrals provided to participants by type:	
- Service(s): Case management, health/medical care, mental health, substance abuse treatment, transportation, and mentoring	347
- Benefit(s): CalWORKs, General Relief, Food Stamps only, Section 8 and/or Shelter Plus Care, SSI/SSDI, Medi-Cal, Veterans	206
- Job/education related service(s): Job training, employment referrals, education	544
Number of participants who do not return to jail	405

Emergency Housing/Case Management	**Quarter**
Average stay at emergency/transitional housing: (11 participants)	109 days
Case management (level 1)	
Average case management hours for each participant per month:	3 hours
Total case management hours for all participants during current reporting period:	1,260 hours
Number of cases per case manager:	34 cases

Longer-term Outcomes (6 or more months) FY 2009-10, First Quarter	
Maintained permanent housing	50
Obtained employment	8
Maintained employment	8
Enrolled in educational program, school	10
Case management	153

Successes: The Just in Reach (JIR) program has enrolled 535 clients to date and averages 190 active clients at any given time who are engaged in services. The unduplicated numbers for this quarter show a new enrollment of 46 individuals. JIR has a recidivism rate that averages about 30% through the first 18 months of the program. This is significantly lower than the 53% report within a similar time frame for the Los Angeles County jail (general) population – and 70% is the average recidivism rate overall for similar populations in County jail. This number is even more impactful if you consider that JIR engages the hardest to serve population of "frequent flyers" in comparison with general population recidivism rates. The program has been measured with similar, more established models in Chicago, New York and Washington DC - and JIR measures up positively.

A total of 194 individuals have been placed in some form of housing during the pilot program. These individuals would have otherwise been homeless upon release if not for the JIR Program. These are impressive placement rates, in light of the fact that JIR clients have limited or no access to housing vouchers; and this success is partially attributed to a complimentary grant leveraged from the Corporation for Supportive Housing that has allowed the program to hire two additional Housing Advocates.

This quarter, JIR established a Landlord Advisory Board in an effort to create more housing opportunities for clients released from jail. Private property owners and public housing providers are brought together in regular meetings for informative sessions to ease concerns to landlords about the population JIR serves. Current landlords of JIR clients voiced their positive opinions on how the program is able to support individuals living independently. The Sheriff's Department participates in these meetings.

In the job training component of the program, 67 individuals have received jobs since the beginning of the program – which reflects approximately 32% of those who are post-release and eligible for employment. The numeric reporting just shows a total number, but does not allow the explanation that many of these participants are still incarcerated and in the pre-release training phase of their program.

JIR staff is in the final stages of negotiating a contract with the local Workforce Investment Board that will allow JIR to place program participants directly into full-time positions at no cost – through a American

Recovery and Reinvestment Act grant. This will enable JIR participants to gain salaried work experience. The partnership will provide transitional subsidized employment to JIR clients whose backgrounds add significant challenges to securing employment.

To date, over 50 mentors have been recruited and currently over 30 mentees are matched with mentors. The mentoring component continues to develop with Jerry Sherk, President and Founder of Mentor Management Systems. Jerry performs mentoring training on a regular basis to new JIR mentors, and provides professional support and guidance to JIR staff. The JIR mentoring program structure is founded on a nationally recognized best practice mentoring model. During the coming quarter, JIR is excited to report that this component will be expanded by leveraging a grant from the Second Chance Act. Recruitment for new mentors is on-going. The JIR Mentor Coordinator reaches out to mentors at local faith-based and educational institutions. In addition, JIR has recruited a number of peer mentors from partnering agencies and reached out to current volunteers in the Los Angeles County Jail system, offering the opportunity to continue their service to the incarcerated through the mentoring program. Peer-to-peer mentoring has proven to be a very successful model in this program. Program participants coming out of incarceration are at a critical juncture in their lives – excited to make changes but overwhelmed by the challenges ahead. To fully take advantage of their "second chance", these individuals need a mentor – a committed caring individual to encourage and believe in them. Having a mentor who can walk them through life's challenges, often proves to be the difference between successful functioning in community or a return to incarceration or homelessness.

Challenges: JIR staff conducts post-release Housing and Employment workshops on a regular basis to keep clients engaged and keep them focused on their goals. Tracking clients post-release has always been challenging because JIR is a voluntary program. Staff has had challenges getting a high level of attendance at these meetings, but as the word gets around, attendance is on the rise. The database administrator, Interthinx (DOMUS), has transferred ownership and all support responsibilities to a new company. This caught JIR off guard and has caused some issues with data collection that has led to even more manual reporting. Reporting with accuracy presents a challenge to staff and they are having to spend a lot of time doing manual reconciliations.

Action Plan: JIR is informing clients while in jail that there will be an incentive for them at the Housing and Employment workshops. The incentives include credits where they can purchase employment ready clothing and other items. Participants are also given an opportunity, through a private grant from the Corporation of Supportive Housing, to acquire housing subsidies for people who attend the workshop, therefore increasing their ability to secure housing. JIR staff continues its participation in employment training, housing training, anger management, crisis intervention which has been incorporated directly to the clients. Staff has applied training materials into workshops pre and post release. These workshops are often accompanied with written materials that are provided to clients.

Client Success Story: A 23-year-old male client from the Men's Central Jail facility w had reentered jail numerous times was enrolled in the JIR program as a frequent user of the County Jail and emergency shelter systems. An employment specialist guided him to a full-time position within three months of release JIR and assisted him in securing credit checks with multiple renters. The client was eventually able to secure housing. This client was actually laid off from his employment after a few months, but due to the case managers insisting he save money within the budget plan they developed, he was able to sustain his housing for a short time until he ultimately secured another job.

19) Long Beach Services for Homeless Veterans

Goal: Assist veterans with housing, employment, SSI/SSDI, and legal issues such as child support. The program provides case management, outreach, and mental health services.
Budget: $500,000 (Ongoing Funding)

Table C.15 : Long Beach Services for Homeless Veterans
FY 2009-10, through December 31, 2009

	Cumulative		Cumulative
Homeless Individuals	1,179	Education	10
Chronic Homeless	153	Job placement	3
Homeless Families	13	Job training	3
Female	145	General Relief (and Food Stamps)	16
Male	1,199	General Relief	6
Transgender	1	SSI/SSDI	6
Hispanic	245	Section 8	1
African American	466		
White	479	Veterans' benefits	37
Asian/Pacific Islander	35	Case management	191
Native American	8	Health care	7
Other	112	Mental health	50
16-24	66	Substance abuse (residential)	10
25-49	677	Transportation	232
50+	602	Life skills	54
		Social/community event	20
Eviction Prevention	2	Other	
Moving assistance	26	Credit repaired	48
Housing (emergency)	131	Legal services	11
Housing (transitional)	47	Driver license reinstated	32
Housing (permanent)	30		
Rental subsidy	14		

Program Specific Measures	Cumulative
Number of mental health coordination activities conducted	50
Number of mental health assessments provided to homeless veterans by MHALA	23
Number of meals provided to homeless veterans. (includes food/meal vouchers)	117
Number of homeless veterans whose child support payment was eliminated or reduced by SPUNK	58
Number of outreach sessions conducted by U.S. Vets and DHHS	30
Number of homeless veterans contacted through outreach sessions by U.S. Vets and DHHS	789
Number of outreach sessions conducted with veterans recently returning from tour of duty	5
Number of mental health educational pamphlets developed	3

Successes: The Long Beach Homeless Veterans Initiative (HVI) partners continue to work closely with the Long Beach Connections Initiative, a grassroots collaborative effort to identify individuals who are homeless and have at risk medical and mental health conditions. Of the 74 veterans identified during the Initiative's survey in July 2009, seven veterans have been placed in housing as the result of the collaborative effort; additionally, one client enrolled in substance abuse treatment. The City of Long Beach Department of Health and Human Services (City) continues to engage in collaborative efforts with the Los Angeles County Department of Mental Health (DMH) to evaluate future funding sources associated with the Mental Health Services Act (MHSA). The Mental Health Coordinator (MHC) through the new LACDMH Veteran's Liaison will be working with various projects including participating in "Another Kind Of Valor," a Town Hall meeting forum that will probe into the needs and wants of combat veterans and their families, including homeless veterans. In addition, the MHC continues to collaborate with VA Long Beach Healthcare System mental health outreach staff. The City is already in the planning stages of the 2010 annual mental health resource event with plans to increase veteran service provider involvement.

This quarter, the HVI partner agencies served 414 veterans with services that included: street outreach, case management, child support reduction, mental health and substance abuse interventions and housing placement. MHALA Homeless Assistant program continues to implement the White Bison Healing Circle, which provides culturally sensitive, recovery-focused mental health services. One of the MHALA outreach staff, also a veteran, uses this group's welcoming and healing attributes as a way to

engage veterans. MHALA has also appointed one of their case managers as the "Veteran's Coordinator," focusing specifically on veterans who come to their Drop-In Center to expedite their connections to mental health services and other veteran resources.

Single Parents United N Kids (SPUNK) provided services for 29 clients with a total of 33 cases. Of the 29 clients, SPUNK closed 14 cases for a total arrears savings of $274,814. These savings included two client cases whose current monthly payment was lowered to zero. One client was able to get his barber license back as a result of this reduction, and he is now providing free haircuts to veterans residing at the U.S. VETS Villages at Cabrillo program.

U.S. VETS recently expanded their Veterans Reentry Project's capacity to serve 23 recently separated veterans. This expansion will allow U.S. VETS to increase services to an underserved veteran population. In addition, U.S. VETS is an active participant in the planning process for the May 20th mental health resource event.

The City continues its outreach efforts to homeless veterans including ongoing referrals to the Long Beach V.A. Healthcare System HUD-Veteran Affairs Supportive Housing (VASH) Voucher program. To streamline the process of enrollment in the VASH Voucher program, the City has provided assistance to veterans in obtaining required documentation and has worked closely with the Long Beach V.A. Healthcare System business office to verify eligibility. The City in partnership with U.S. VETS participated in the City's Veteran's Day celebration on November 7, 2009 and outreached to many recently separated veterans attending this celebration.

Challenges: MHALA continues to experience low numbers of veterans coming to their "Drop In" center for their Homeless Assistance Program (HAP). U.S. VETS continues to face the challenge of filling their current veteran's street outreach position. Additionally, due to limited access to military bases, the City and U.S. VETS are participating in community events, such as the Veteran's Day celebration, to engage veterans.

Action Plan·

- MHALA will appoint a "Veteran's Coordinator" that will be available to engage veterans who come to their Drop-In Center to facilitate mental health service connection.
- US VETS will utilize currently employed outreach staff to conduct veteran's specific street outreach until the vacancy of "Veteran's Outreach Worker" is filled.
- The HVI Partners will maintain relationships with other service providers and advocacy groups such as the Long Beach V.A. Healthcare System, LACDMH and Long Beach Connections to broaden resources available for veterans in need of mental health and medical services and housing.
- The HVI Partners will continue to investigate and utilize funding opportunities through the Homeless Prevention and Rapid Re-Housing Program under the ARRA and future MHSA proposal opportunities.
- The HVI Partners will continue to participate in community events and programs that provide opportunities for outreach and engagement to veterans in the City of Long Beach.

Client Success Stories: Upon discharge from active duty service in the United States Army, client and spouse, both recently separated veterans, and three children settled in Lakewood, CA with spouse's family. Due to situational circumstances, the family was displaced in December 2009. The homeless family sought help at the Long Beach V.A. Healthcare System and was referred to U.S. VETS – Long Beach. U.S. VETS does not provide family housing, however the client was provided with temporary housing at the Veterans Reentry Project (VRP). The wife and children were provided housing and services at the newly-opened veteran's Mothers with Children program on the same campus at Villages at Cabrillo. Despite living in separate residences, the family was able to remain close to one another (less than 100 meters) during this period. U.S. VETS provided intensive case management to the family and assisted with employment search. The family was referred to the People Assisting the Homeless (PATH) family housing at the Villages at Cabrillo. The family is now reunited and living under the same roof.

MHA street outreach team has been outreaching to a veteran named J for many years. He was known to

live under a local freeway underpass. Due to his mental health symptoms, MHA outreach worker would observe J sleeping most of the day with little motivation to do much else. Through MHA intensive outreach, J felt comfortable enough to come to the Drop-In Center. He was provided case management assistance to improve his living arrangements, including reconnection with his son. MHA assisted with his application to SSI. He was then linked to the Psychiatric Nurse Practitioner, who performed an assessment and provided medications. J continues to meet with the Nurse Practitioner on a regular basis for ongoing mental health support and therapy.

Client N is a 46-year-old homeless veteran who was referred to SPUNK through the U.S. VETS program at the Villages of Cabrillo in Long Beach. The client had two child support cases in Los Angeles County. He suffers from multiple medical and mental health issues as a result of his military service and is currently applying for a service-connected disability. The two cases consisted of one seven-year-old in which the client owed approximately $42,000 and a second 10-year-old child with an approximate debt of $25,212 in back child support to welfare. SPUNK was able to have the first case dismissed by a judge due to written documentation that N was in prison at the time he was served. As a result, N does not have to pay the money, saving him over $42,000. SPUNK filed a Compromise of Arrears on the second case. The County reduced what he owed from $25,212 to $2,521. The total savings on both cases was $65,129. The client was able to get his driver’s license released and his credit cleared. Due to the fact the client owed back child support, he often worked, "under the table” and employers would take advantage of him. The client is looking forward to working again under legitimate circumstances.

20) Los Angeles County Homeless Court Program

Goal: Assist homeless individuals with clearing outstanding tickets, fines, and warrants upon successful completion of rehabilitation recovery programs for mental health, substance abuse and/or other issues.
Budget: $379,000 (On-going Funding)

Table C.16 : Los Angeles County Homeless Court Program Participants
FY 2009-10, through December 31, 2009

	FY	Cumulative		FY	Cumulative
Homeless Individuals	540	1,728	Hispanic	126	407
			African American	265	883
Female	185	587	White	117	348
Male	354	1,137	Asian/Pacific Islander	17	32
Transgender	1	4	Native American	8	14
			Other	7	44
Alternative court	482	1,648			
Transportation	56	73	15 and below	-	-
Food card	128	128	16-24	55	151
Housing (emergency)	19	19	25-49	334	1,102
Substance abuse treatment (residential)	2	2	50+	151	475

Program Specific Measures	FY	Cumulative
Number of Los Angeles County Homeless Court motions received	1,563	4,952
Number of program participants whose qualifying motions are submitted to and filed by Superior Court, and resolved within 30 days of submission	1,545 100%	4,952 100%
Number of audited records in the Superior Court's automated case management systems (TCIS/ETRS) that are accurate	79 100%	226
Number of motions that are granted by Superior Court	1,523 100%	4,848
Number of motions that are denied by Superior Court	-	8
Number of individual cases filed under the Los Angeles County Homeless Court	1,600	5,493
Number of participants whose applications are submitted to the Los Angeles County Homeless Court within 30-days of initial contact with participant	455	1,570
Number of participants that have Los Angeles County citations or warrants dismissed upon program completion	369	1,491
Number of participants who complete at least 90 days of necessary case management, rehabilitative, employment or mental health services before their first appearance in Court	482	1,642
Number of case managers who receive training on Los Angeles County Homeless Court benefits, application and eligibility requirements, and legal resources	411	1,376

Successes: In December 2009, the Beverly Hills City Council voted unanimously to approve a parking ticket forgiveness program that will be integrated into the Los Angeles County Homeless Court Program. Clients who participate in the parking ticket forgiveness program must meet all of the eligibility criteria for Homeless Court, including participation in a case management program for at least 90 days, not having received any new violations within the six months prior to applying and no outstanding felony warrants. Clients who are still in possession of the vehicle that incurred the parking tickets will have their tickets dismissed through the program. This is an important success because many Homeless Court clients have unpaid parking tickets in addition to their traffic and quality of life offenses, and these tickets can pose a barrier as they attempt to renew their driver's license and vehicle registration. In addition, accumulated parking tickets can result in a car being impounded, limiting an individual's ability to seek services or employment. The Beverly Hills City Council's support of this program, which was proposed and will be administered by Public Counsel, will hopefully lead to support for parking ticket forgiveness programs in other cities in Los Angeles County.

Superior Court continues to build stronger working relationships with newly assigned staff with Public Council and the Los Angeles City Attorney, without interrupting the quality of service to the program's clients.

Challenges: One challenge during this quarter was the transfer of Judge Gregory Dohi. Judge Dohi has contributed greatly to Homeless Court by signing motions and presiding over Homeless Court sessions, and his new position may not allow him to continue his same level of involvement with the program. While Judge Michael Tynan continues to preside over Homeless Court sessions, the Homeless Court staff hopes to recruit additional judicial officers to preside over sessions so that this responsibility can continue to be shared.

Public Counsel also experienced additional staff turnover during the quarter, and as a result, the processing of Homeless Court applications has slowed temporarily while new staff is trained and develops familiarity with Homeless Court policies and procedures. Finally, Public Counsel continues to experience difficulties in receiving resolutions for citations from the Cities of Pasadena, Torrance and Inglewood in a timely and consistent manner.

Superior Court has received motions that are at times incomplete and appear to not have been thoroughly reviewed for eligibility. As a result, several motions were returned as ineligible and not processed. Superior Court believes that a review of eligibility and format requirements with the prosecutors will address this concern.

Action Plan: Public Counsel is addressing the challenges described above by hiring a part-time administrative assistant to join the Homeless Court team and actively recruit volunteers to assist with administration of the Homeless Court Program. In addition, Public Counsel's Homeless Court team is working with its Homeless Court partners to identify judicial officers to assist in presiding over Homeless Court sessions. With regard to the ongoing challenge of timely and consistent resolution of citations from the Cities of Pasadena, Torrance and Inglewood, the Homeless Court staff attorney will meet with the appropriate individuals in each jurisdiction to enhance coordination and improve the resolution process.

Superior Court will be working with Public Council to review workflow and eliminate duplicative processes. The program is working to decrease the average turnaround time from the point of receipt of a case by Superior Court to Public Counsel.

Client Success Story: Client X was referred to Homeless Court by her case manager at a program that assists at-risk young adults with education, job skills and employment opportunities. She had 17 citations resolved through Homeless Court, and in December 2009, she completed a Certificate in Industrial Hygiene. Client X is now employed full-time.

Client Y was referred to Homeless Court by his counselor at a drug abuse treatment center. After having seven citations resolved through Homeless Court and receiving training to become a petroleum inspector, Client Y is now employed full-time.

21) Moving Assistance for Single Adults in Emergency/Transitional Shelter or Similar Temporary Group Living Program

Goal: Assist individuals to move into permanent housing.
Budget: $1.1 million (One-Time Funding)

Table C.17: Moving Assistance for Single Adults Program Measures
FY 2009-10, through December 31, 2009

(unduplicated count)	FY	Cumulative		Cumulative
Homeless Individuals	516	1,283	Female	357
			Male	580
Number applications received	516	1,283		
Moving assistance approved	142	332	16-24	46
Percent applications approved	28%	29%	25-49	435
Average days to approve	10	*	50+	456
Average amount of grant	$519	**	Hispanic	120
			African American	588
***			White	195
General Relief (w/FS)	266	428	Asian/Pacific Islander	1
General Relief only	31	31	Native American	26
Food Stamps only	50	59	Other	7
Medi-Cal/Medicare	-	1		
SSI/SSDI	41	61	*Demographic information was not available for all clients during FY 2007-08.*	
Section 8	3	4		
Shelter Plus Care	2	12		
Veterans' benefits	14	16		

* FY 2007-08 average was 20 days; FY 2008-09 average was 12 days.
**FY 2007-08 average was $575; FY 2008-09 average was $722.
***Cumulative data for benefit information only includes FYs 2008-09 and 2009-10.

Successes: The program maintained a steady increase in the number of referrals for this reporting quarter.

Challenges: To date, the program is still experiencing a low number of approvals despite the increase in referrals.

Action Plan: The program plans to continue outreach efforts at transitional shelters and other agencies that provide services to the homeless population. This project is scheduled to end on June 30, 2010.

Client Success Story: Mr. G, a homeless participant, had difficulty in getting a job because of his situation. Fortunately, Mr. G was referred to the Single Adults Move-In Program and was provided the security deposit to move into permanent housing. The move enabled Mr. G to search and apply for employment. He called his HPI Eligibility Worker to inform him that he has gone for several interviews and may be offered a permanent job soon.

22) Project 50

Goal: To move 50 of the most vulnerable, chronically homeless individuals off of Skid Row and into permanent housing.
Budget: $3.6 million (Board Approved Funding)

Table C.18: Project 50 Participants and Services
FY 2009-10, through December 31, 2009

(unduplicated count)	FY	Cumulative		FY	Cumulative
Chronic Homeless Individuals (ever housed)		58	Education	-	2
			Job training/referrals	-	2
Female	2	7	Job placement	-	2
Male	3	50			
Transgender	-	1			
			General Relief (GR,FS)	2	12
			General Relief only	3	10
			Food Stamps	1	2
Hispanic	1	12	Medi-Cal/Medicare	5	21
African American	3	46	Section 8	-	1
White	1	7	Shelter Plus Care	5	46
Asian/Pacific Islander	-	-	SSI/SSDI	11	42
Native American	-	-	Veterans	7	15
Other	1	1			
			Case management	38	41
25-49	1	17	Health care/medical	37	41
50+	4	41	Mental health/counseling	35	38
			Social/community activity	-	30
Eviction prevention	7	15	Substance abuse (outpatient)	-	20
Housing (emergency/transitional)	7	48	Substance abuse (residential)	5	14
Housing (permanent)	5	58	Transportation	-	35
Rental subsidy	-	41	Legal Services	-	11
Moving assistance	1	2			

Longer-term outcomes (at 18 months)	**Quarter**
Continuing to live in housing	46
Enrolled in educational program	2
Case management	41
Health care	46
Good or improved health	30
Mental health/counseling	31
Good or improved mental health	21
Substance abuse treatment (outpatient)	24
Substance abuse treatment (residential)	12
No drug use	9
Reunited with family	5

Case management	**Quarter**
Level 3 case management services	
Average for each participant per month:	4 hours
Total hours for all participants:	107 hours
Number of cases per case manager:	23 cases

Successes:
Housing retention rates:

- At 6 months: 37 total housed; 33 remained housed (or alt housed) – 89.2% retention rate
- At 12 months:49 total housed; 42 remained housed (or alt housed) – 85.7% retention rate
- At 18 months:59 total housed; 51 remained housed (or alt housed) – 86.4% retention rate

Program Specific Measures	FY	Cumulative
Number of participants who exited housing	-	11
Number of participants developing individualized treatment plans	5	46
Number of participants participating in a housing retention group	-	30
Number of Project 50 participants having arrests	6	21
Number of Project 50 participants having hospitalizations	3	18
Number of Project 50 participants having an emergency room (ER) visit	6	12
Number of Project 50 participants with increased income (i.e., due to SSI/SSDI, GR)	5	21

Project 50 was one of the top ten recipients of the Quality and Productivity Award for 2009. Project 50 has an 89% housing retention rate along with a 70% rate of participants with SSI. Specifically, 32 people have received SSI, and 11 applications have been submitted for the remaining participants. Two have been denied for various reasons. This past quarter, a person who suffered from severe alcoholism is now stable and in permanent housing.

The goal for the project is for homeless participants to be sustained in permanent supportive housing. The project has also demonstrated that various County, City and non-profit agencies can work together as a team to make this project a success. Project 50 staff has initiated a Community Integration program that encourages participants to visit various cultural and recreational attractions throughout the city. The most recent trip to the J. Paul Getty Museum in Brentwood was a rousing success. The participants had a personal tour and several expressed a desire to return again to this wonderful cultural icon. Project 50 continues to innovate and support participants as they integrate into and maintain stable housing.

Challenges: Working as a team, the Project 50 staff has had significant success in maintaining housing for the chronic homeless. The team continues to work with clients to resolve substance abuse, poor money management, and rental payment issues.

Action Plan:

- Utilize other agencies to assist in locating appropriate potential participants for housing. The Project 50 staff have refreshed the Registry to concentrate outreach and engagement activities on an ongoing basis;
- Encourage staff stability, explore development of a process group for participants to deal with loss;
- Continue to add participants to continually have 50 clients currently housed; and
- Hire a money manager and continue intensive substance abuse interventions. Develop money management skills. Work with residents who are at risk of falling behind on their rent.

Client Success Story: A participant came to P50 very depressed and on GR. He received psychiatric care and improved significantly. In addition, he received SSI. The client is now very content and stable in housing.

23) Santa Monica Homeless Community Court

Goal: Assist homeless individuals with clearing outstanding citations, warrants, and misdemeanor offenses upon successful completion of mental health, substance abuse and case management.

Budget: $540,000 (Board Approved Funding); $31,000 for transitional housing

Table C.19: Santa Monica Homeless Community Court Participants and Services
FY 2008-09, Cumulative (February 2007 – June 2009)

(unduplicated count)	Cumulative		*Cumulative
Chronic Homeless Individuals	155	15 and below	-
		25-54**	121
Female	49	55+	34
Male	106	Housing (emer/trans)	66
		Housing (permanent)	26
Hispanic*	17	Rental subsidy	11
African American	34		
White	102	Alternative court	155
Asian/Pacific Islander	3	Case management (level 3)	148
Native American	1	Mental health	65
Other	15	Substance abuse (outpatient)	5
		Substance abuse (residential)	32

Program Specific Measures	Cumulative
Total number of clients who have enrolled in Program	155
Number who participate that have citations or warrants dismissed upon completion	118 (76%)
Number who receive an emergency shelter bed and remain for two weeks or longer	35 (53%)
Number who accessed psychiatric and/or mental health services, received their mental health services at a DMH facility within the six-month program period (February-June 2009)	24 (37%)
Number who enter residential treatment complete a substance abuse program of 90 days or longer	24 (71%)
Number of arrests for all Court participants that have been placed in an emergency, therapeutic, transitional or permanent bed (or some combination of bed-types) for 90-days or longer as compared to the 90 days prior to entering residential program	70% reduction
Number of permanently housed who continue to be housed after four months, or will still be housed at the end of the program periods (which may be less then four months after housing placement)	24 (92%)
Average length of stay in emergency housing:	14-160 days

*Latino is not categorized as a distinct race by Santa Monica Homeless Community Court.
** Age range is categorized differently by Santa Monica Homeless Community Court.

Successes: The most successful ongoing collaboration which the Homeless Community Court program is engaged in is its relationship with Edelman Mental Health Center. Every Thursday morning, the Edelman psychiatrist and social worker, provide in-office services at the St. Joseph Center Homeless Services Center and occasional outreach to Homeless Community Court clients. The primary benefit of this Edelman collaboration is giving clients easy access to psychiatric care, with medications administered at two area pharmacies. Given the limited mobility, organization and/or motivation of many Court clients, this is often a superior service option to conventional mental health clinics. Integrating these psychiatric services into the pre-existing relationship which clients have with their program Case Manager and Mental Health Specialist also provides context which can help overcome service barriers stemming directly from mental health symptoms. A secondary but lasting benefit of the Edelman collaboration is streamlining the eventual transfer of client services from in-office services at the Homeless Services Center to long-term mental health care at Edelman or other Department on Mental Health facilities.

Exodus Full Service Partnership (FSP) has been another valuable collaborator with the Homeless Community Court Program. A dually diagnosed client referred to this program was rapidly entered into intensive services with an outreach case manager. Working in tandem with Homeless Community Court and Exodus staff, this client was able to access a full range of services including psychiatric care,

substance abuse treatment, emergency shelter, and permanent housing at a sober living. The FSP's collaboration with Exodus Mental Health Urgent Care Center accelerated the client's access to mental health services and dealt with acute mental health situations. This collaboration has also contributed to St. Joseph Center's familiarity with the services offered by Exodus Urgent Care, benefiting the agency more generally. Building on the success of the Chronic Homeless Program (CHP), the program has managed to link many CHP participants to the Court which has resulted in the removal of barriers and has allowed for the successful transition by clients to the next phase of their lives. Continued collaboration between service providers, police and fire has allowed the program to continue engaging clients in the field and seizing opportunities to refer them to the program, when it appears they will be receptive to services. The program's talented Public Defender is greatly appreciated not only by the Resource Coordinator but also by the service providers. She creatively strikes a balance between advocating for her clients and using her motivational interviewing techniques to help clients see the benefits of connecting to services.

Challenges: The voluntary nature of the program allows many of the most chronic, high users of police, fire and social services the opportunity to opt out of the program. These are the very people the program had wished to engage in services using the authority of the Court. Experience has shown that many of the most chronic homeless do not want to access services. Moreover, the voluntary nature of the program does not allow the program to use the authority of the Court to connect individuals to much needed resources, including: mental health, psychiatric, medical, substance abuse and monetary assistance programs – all of which can be barriers to stabilizing clients, housing them and helping them maintain their housing.

Action Plan: The Court will only accept participants cited with quality of life crimes – misdemeanors and infractions. The Court will not accept felons or sex offenders. The very nature of the crimes, misdemeanors and infractions, prevent the court from following participants for extended periods of time and result in citations being dismissed with limited client progress. Greater oversight by the Court could have a very positive influence on participants and result in better outcomes. Currently, participants average 2-3 court visits before their citations and warrants are dismissed. This impacts both substance abuse treatment and housing placements. Indeed, because of Case Management initiated by the Court, some individuals may achieve outcomes months after their exit from the program.

Court participants would benefit from a more directive tone and more exact prescriptions from the Court. While this has improved, the program continues to need progress in this area. The court appointed psychiatrist linked with the program supports this change in tone of court orders, and feels that it would result in greater client success. Furthermore, it would lend more objective finality to the process, taking out a great deal of ambiguity for the client.

Table C.20: Santa Monica Homeless Community Court (transitional housing and services)
FY 2009-10, Second Quarter

Homeless Individuals	5	Housing (transitional)	5
White	5	Job training	5
24-49	3	Job placement	2
50+	2	Veteran benefits	2
		Substance abuse treatment (residential)	5

Successes: Eventually, one participant moved into his own apartment. Two participants who completed the CLARE Foundation's program received employment.

Challenges: It has been challenging for participants to stay in the program.

Action Plan: Staff continues to reinforce the benefits of staying in the program.

24) Santa Monica Service Registry

A) Step Up on Second
Budget: $ 518,000 (Board Approved – Third District)

Table C.21: Step Up on Second, Santa Monica Service Registry
FY 2009-10, through December 31, 2009

(unduplicated clients)	Cumulative		Cumulative
Chronic Homeless Individuals	27	Moving assistance	17
		Housing (transitional), 38 day stay	16
Female	9	Housing (permanent)	14
Male	18	Housing (emergency)	4
		Eviction prevention	4
Hispanic	5	Rental subsidy	17
African American	5	Legal	4
White	15	General Relief with Food Stamps	1
Asian/Pacific Islander	2	Medi-Cal/Medicare	2
		Case management	26
25-49	13	Health care	6
50+	14	Life skills	26
		Mental health care	26
		Social/community activity	26
Job training	1	Transportation	26
Section 8	2	Substance abuse treatment (outpatient)	3
Shelter Plus Care	4	Substance abuse treatment (residential)	4
Education	1	SSI/SSDI	1
		Alternative court	2

Case management level 3	**Quarter**
Average hours per case:	24
Total number of hours:	627
Caseload per case manager:	6
Longer-term outcomes (six or more months)	
Continuing to live in housing	4
Continuing to receive rental subsidy	4
Case management	16
Health care	14
Good or improved physical health	14
Mental health care	16
Good or improved mental health	16
No drug use	9
Number of organizations/agencies that your program has a formal collaboration for this project	5
Number of times collaborative partners met each month	3
Total amount ($) of HPI funding leveraged for project	$2,645,657
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	68%
Total number currently enrolled in program	26
Number of participants who left the program during this period	1
Number of clients who received an assessment (if applicable)	26
Cost per participant	$376
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning / end*** of the quarter	- -

Successes: In the past quarter, the Step Up HOME Team has had been successful in connecting individuals to permanent housing options. Step Up placed five new participants into permanent housing, three into transitional housing and two in emergency shelters. Step Up assisted a participant in engaging an educational opportunity, and she is now studying for her G.E.D. One participant obtained Medi-Cal benefits and two obtained SSI/SSDI benefits. The Step Up HOME Team aided others with addressing their substance abuse issues with placement into detox and an outpatient treatment program. In longer term outcomes, Step Up has been successful in assisting four participants maintain their permanent housing for six or more months. They continue to receive a rental subsidy to accomplish this goal. Through Step Up's outreach efforts to landlords and property managers in the community, the program

has been able to create and nurture relationships that benefit participants. Landlords are pleased with the response they see from the team and are now calling, when they have vacancies to fill.

Challenges: There are several challenges in assisting chronically homeless individuals into permanent housing. It is difficult to prepare a client for the interview process with a landlord due to their emotional state and appearance. Clients can become resistant, uncomfortable and even experience a triggering of their symptoms from the pressure of having to meet with a person of authority and fill out paperwork to apply for housing. Landlords may not be familiar with the Section 8 process and may have had some previous experiences with Section 8 that cause them to pause when considering the chronic homeless population. In Santa Monica, the team has an additional challenge of finding apartments that are compatible with the monetary cap of Section 8 requirements. Finally, participants are subject to the fears and bias people have about mental health issues. Also, there is self-stigma which leaves individuals living with a mental illness to feel powerless, causing them to settle for less than they deserve or not even attempting to utilize these housing opportunities.

Action Plan: The Step Up HOME Team will continue to acquire Section 8 vouchers and increase benefits for participants. The team will educate and encourage participants to engage in a money management program to assist them in improving their financial situation so they will be prepared to pay rent and a deposit when housing options are available. They will assist participants in navigating the legal system to reduce or remove legal barriers to housing and growth. The program will educate participants in presentation skills and better prepare them for interviews. In addition, the program will outreach to landlords and property management companies in the community to educate them about the Section 8 program and encourage their participation. Through such resources as Craigslist, the program advertises to landlords willing to accept Section 8 voucher holders. During home visits with participants who are housed, staff will assist in improving their life skills so that they can maintain their home and retain their housing. Moreover, the program will continue to assist participants in maintaining their physical health through connections to medical and dental care.

Client Success Story: Client L initially became a member of Step Up On Second in May 2001 and presented with a diagnosis of Major Depressive Disorder. She was referred to mental health case management and psychiatric services in December 2002 at the agency. Client L was then housed through the Section 8 program in March 2003. She received GR benefits at this time and eventually applied for and was granted SSI benefits. Prior to and during her being housed, she struggled with substance abuse which eventually led to her being evicted from her apartment in October 2005. From there she lived on the streets of Santa Monica for three years and continued to struggle with her substance abuse and had with very limited contact with her treatment team. During this period of time, she became familiar to the Santa Monica Police Department and was arrested on several occasions. Eventually, she was sentenced to jail for a probation violation and failed to enter a substance abuse program.

Upon release from jail, she reconnected with Step Up On Second and her treatment team. She was referred to and accepted into Daybreak Shelter in April 2008. From there she was enrolled into a money management program and attended substance abuse and other life skills groups. In November 2008, Client L was transferred to the Step Up HOME Team, and they assisted her in applying for a Section 8 voucher. She received her voucher and was assisted in locating an apartment. She moved into permanent housing in March 2009 where she remains. She recently enrolled into a GED program and has hopes of continuing her education further. The client continues to maintain her sobriety, meets with her treatment team as scheduled and meets with the HOME Team members at least twice monthly. She continues to show progress towards making improvements and positive changes in her life.

B) OPCC Safety Net (Access Center)
Budget: $ 660,000 (Board Approved, Third District)

Table C.22: OPCC Safety Net (Access Center)
FY 2009-10, through December 31, 2009

(unduplicated clients)	Cumulative		Cumulative
Chronic Homeless	47	Section 8	10
		SSI/SSDI	7
Female	13	Shelter Plus Care	8
Male	34	Job placement	1
		Job training	4
Hispanic	2		
African American	10	General Relief with Food Stamps	3
White	32	General Relief	2
Asian/Pacific Islander	1	Food Stamps	2
Native American	-	Alternative court	4
Other	2	Case management	41
		Health care	16
25-49	21	Mental health care	24
50+	26	Substance abuse treatment (residential)	5
		Substance abuse treatment (outpatient)	8
Housing (emergency)	32	Food	13
Housing (transitional), avg. stay 20 days	7	Clothing	2
Housing (permanent)	15	Transportation	19
Rental subsidy	11	Life skills	9
Moving assistance	12	Recuperative care	1
		Case management level 3	
		Average hours per case:	350
		Total number of hours:	1,050
		Caseload per case manager:	11
Longer-term outcomes (six or more months)			
Continuing to live in housing			5
Receiving rental subsidy			3
Case management			23
Health care			13
Good or improved physical health			13
Mental health care			8
Good or improved mental health			8
Number of organizations/agencies that your program has a formal collaboration for this project			3
Number of times collaborative partners met each month			1
Total amount ($) of HPI funding leveraged for project			$2,238,567
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)			54%
Number of participants who have enrolled (entered) into program during the reporting period			4
Number of participants who left the program during this period			3
Total number currently enrolled in program			39
Number of clients who received an assessment (if applicable)			-
Cost per participant			$2,930
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter			n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter			n/a

Successes: By the end of the quarter, OPCC Project Safety Net successfully assisted a total of 15 chronically homeless individuals on Santa Monica's Service Registry to secure or maintain permanent housing. Among 40 clients from the previous quarter, one person was deceased, one opted out of participation, one individual's whereabouts was unknown and one woman was reunified with her mother, residing in a board and care home out of state. Staff identified eligible clients to fill these available openings, and all of those clients have already been initially engaged.
A total of 23 individuals are temporarily or permanently housed and off the streets. Five individuals obtained an apartment during the quarter; one client remained in transitional housing at a sober living

facility. Five clients maintained emergency housing in master-leased units or shelter. Six clients secured housing vouchers and a seventh individual had a voucher pending. All of these individuals are working on locating apartments with assistance from OPCC Project Safety Net.

Challenges: Locating housing for clients has remained a significant challenge, but through the creativity and persistence of staff, clients have been able to locate scattered site apartment units within the average timeframe of 3-4 months and a range of one month to one year.

In addition to substance addiction, the single most challenging issue has become serious untreated mental illness, including resistance to treatment, paranoia and suspicion. Many of the alienated individuals are resistant (or ambivalent) and fear coming off the street. This is the case even when permanent housing is offered. Staff must utilize much creativity, flexibility, and persistence in developing trusting relationships. A consulting psychiatrist was hired at the end of the quarter to address this challenge. Supporting housed clients with special needs who require intensive life skills training continues to grow as a significant challenge as more individuals become housed.

Action Plan:

- OPCC hired a new psychiatrist at the end of this quarter. The upcoming focus for psychiatric services will be to provide psychiatric outreach to individuals on the streets.
- OPCC Safety Net continues to creatively recruit landlords and provide them with the intensive support required for them to be willing to participate in our housing program.
- The staff team continues to foster a good working relationship with the SMPD's Homeless Liaison Program to move clients forward into services

Client Success Story: Client C has been homeless for nearly two decades and was one of the most recognized "high utilizers" of public services in Santa Monica. When OPCC Project Safety Net began working with her, she was in a wheelchair and incontinent. The client's alcoholism and her symbiotic relationship with her street boyfriend who also suffered alcoholism were the most significant challenges to her success. She also suffered from untreated mental illness, further complicated by the extent of her drinking. Client C refused all services for substance abuse, and as a result, was unable to stay in any shelter. At times she was able to sustain a short stay in a motel room, but required extensive support from staff to keep it clean and care for herself, and on several occasions her boyfriend would find her in a motel, or the hospital, and abscond with her back to the street. It was clear that a harm reduction approach was necessary to move the client forward. Through intensive staff support and counseling utilizing harm reduction methods, and medical services provided by Venice Family Clinic, staff assisted her in obtaining SSI income and a Shelter Plus Care housing voucher and then her own apartment. During December, the client had to be hospitalized and the outcome is not known, but thankfully, she went to the hospital from her own home with a residence to return.

IV. PROGRAMS FOR MULTIPLE POPULATIONS

25) Los Angeles County Housing Resource Center, (LACHRC; formerly known as the Socialserve Housing Database)
Goal: Provide information on housing listings to public users, housing locators, and caseworkers.
Budget: $382,000 ($202,000 allocation from HPI funding and $180,000 from CDC).

Table D1: LACHRC Program Measures **June 1, 2007 – December 31, 2009**	**Cumulative**	**Year 1 6.1.07 - 6.30.08**
Number of landlords registered on the site	8,901 *1,496 new*	3,505
Average monthly number of units available for rental	3,913	1,324
Total housing unit/ apartment complex listings registered on site (includes units that have been leased) *(as of December 2008)*	14,700 *3,526 new*	5,171
Total number of housing searches conducted by users that returned listing results	4,017,605 *325,531 new*	1,590,825
Average number of calls made/received to the Socialserve.com toll-free call center per month	3,637	2,897
Number of collaborative efforts forged between County Departments, Cities, and other stakeholder agencies	83 *5 new*	33

Successes: Partnership efforts with the City of Pasadena, the Apartment Association of Greater LA, and the Housing Authority of the City of Los Angeles (HACLA) led to a dramatic increase in the number of landlords using the site. During this quarter, 1,496 new property owners signed on, and the number of available rental units grew by 66% from 2,989 to 4,977. The American Recovery and Reinvestment Act (ARRA) Homelessness Prevention and Rapid Re-Housing Program (HPRP) pre-screening function was also successfully launched for the County's program, and the tool is being widely implemented.

Challenges: The additional requirements of administering the website features related to the two stimulus fund programs (Housing and Economic Recovery Act – Neighborhood Stabilization Program) and (ARRA-HPRP) have added unexpected complexities and time pressures to the project administration.

Action Plan: The primary goal of this upcoming quarter is to improve marketing of the website features, focusing primarily on HPRP program marketing. Additional outreach will be done to County departments to offer training and improve awareness of the website tools for special needs housing search and placement.

Client Success Story: A Los Angeles County property owner called the contractor, Socialserve.com, to compliment one of the Call Center staff for helping her list her rental property on the website. She stated, "Maylin was outstanding. She took her time. I didn't feel rushed. She helped with every part of listing my property, and I appreciate that."

26) Los Angeles Homeless Services Authority (LAHSA) Contracted Programs

Goal: Emergency shelter and transitional housing are provided to families and individuals.
Budget: $1,735,000 (One-Time Funding)

Seven programs are currently in progress: two emergency shelters, three transitional housing, and two permanent supportive housing programs.

Table D.2: LAHSA Participants and Services

(unduplicated clients)	FY 2007-08	FY 2008-09	FY 2009-10 Dec. 2009	Total
Homeless Families	483	275	77	835
Homeless Individuals	3,162	890	74	4,126
Chronic Homeless	2,206	358	83	2,647
Female	1,938	493	154	2,585
Male	3,931	1,003	121	5,055
Hispanic*	1,385	647	145	2,177
African American	2,838	636	218	3,692
White	2,004	1,097	141	3,242
Asian/Pacific Islander	151	83	32	266
Native American	168	110	-	278
Other	1,598	99	59	1,756
Adult	6,064	1,550	251	7,865
Child	1,029	444	177	1,650
Transition Age Youth *(not included as individuals)*	-	91	24	115
Emergency housing	5,869	1,462	96	7,427
Transitional housing	-	156	81	237
Permanent supportive housing	-	-	81	81

**LAHSA uses the federal definition of Hispanic origin (which for the Feds includes all Spanish speaking nations in the Americas and Spain). There are two options: Hispanic or Non-Hispanic.*

***The U. S. Department of Housing and Urban Development (HUD) defines an adult as a person 18 years of age or older. LAHSA uses the HUD definition of adult in its data collection process.*

27) PATH Achieve Glendale
Budget: $150,000 (One-Time Funding)

Successes: The clients of PATH Achieve Glendale's Access Center (PAG) have experienced notable successes in the face of a challenging economic climate. Concerted efforts to serve local chronically homeless individuals have resulted in several people who had been living on the streets for years being placed in supportive and/or subsidized housing. The work has been slow-going and intensive. It called for a team approach including staff from PATH Achieve Glendale's outreach team, Access Center case managers, social workers, and a psychiatrist working together with community service providers. PATH Achieve Glendale's outreach team is the sole provider for case management services at the local Winter Shelter Program. In addition, the Access Center continued to provide services to the region's homeless individuals and families.

Challenges: Case managing chronically homeless individuals with very little available appropriate housing has been a great challenge. The last several months have proven that the chronically homeless individuals on Glendale area streets are interested in housing. Moreover, they are willing to take necessary steps - even drastic ones. They seek support to move into housing, when subsidized housing is available. Obtaining reliable reports from the Homeless Management Information System remains challenging.

Table D.3: PATH Achieve Glendale
FY 2009-10, through December 2009

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	505	15 and below	336
Chronic Homeless	129	16-24	151
Homeless Families	*265	25-49	665
(Individuals)	796	50+	264
Female	715	Housing (emergency)	345
Male	705	Housing (transitional), *average stay 53 days*	**66
		Housing (permanent)	242
Hispanic	436	Moving assistance	40
African American	527		
White	404	Job training	60
Asian/Pacific Islander	26	Job placement	6
Native American	19	CalWORKs	2
Other	8	General Relief and Food Stamps	27
		Medi-Cal/Medicare	2
Case management (level 3)	183	SSI/SSDI	23
Number of cases per case manager	76	Health care	32
		Life skills	13
		Mental health care	30
		Social/community event	20
		Substance abuse treatment (outpatient)	47
		Substance abuse treatment (residential)	1
		Transportation	61

**A total of 796 individual family members was served; the number of families was calculated by dividing by three (estimated average family size).*
***FY 2008-09 Transitional and permanent housing placement was estimated based on the ratio of transitional to permanent housing placements indicated in HMIS reports. The total number of placements (61 residents) was verified by an Emergency Housing Program report.*

Action Plan: PATH Achieve Glendale's Access Center will continue to provide case management and other supportive services to the region's homeless population. The outreach team will continue to provide case management for the families and individuals of Glendale's Winter Shelter Program. The Access Center will initiate a drive to further inform regional service providers about PAG services to recruit individuals and families that can use case management and emergency services.

Client Success Story: For over 20 years, Client A lived on the streets intermittently. She had a couple of marriages, bore two children, endured physical and mental abuse from both husbands, fled both men, took the kids and ended up on the street a homeless single parent, living on government benefits.

The client was born in an Italian detention camp during World War II; her father was Jewish, her mother a Hungarian Catholic. The family survived the war and came to the U.S., eventually landing in Los Angeles. The family, according to the client never outlived the chaos and uncertainty of the war. The client survived, but she also suffered wounds that never healed. At age 66, she was once again was the victim of an abusive relationship. Her partner held her semi-captive in a camper that they shared for nearly two years. Despite being challenged by a serious heart condition, she broke away and literally stumbled upon PATH Achieve Glendale and entered the emergency housing program.

During her 87 days at PATH Achieve Glendale, she was under the care of several doctors, was in surgery twice to receive and repair a pacemaker, was hospitalized twice for a few days, underwent a transfusion and two painful biopsies, and had numerous tests to determine if she had cancer. Through it all, she was adamant that she wanted her own place. Regardless of her precarious physical health or perhaps because of it, she tenaciously pursued her housing goals. She was referred to an affordable Single Room Occupancy (SRO) unit by her case manager. She moved into the SRO with a microwave and refrigerator provided by PATH Achieve Glendale. It has been a long road; a difficult life. The client now has an address, a key to her own room, privacy, and dignity.

28) Pre-Development Revolving Loan Fund (RLF)

Goal: Affordable housing developers will receive loans directly from the Los Angeles County Housing Innovation Fund, LLC (LACHIF) to build much needed affordable housing in Los Angeles County.

Budget: $20 million (One-Time Funding)

Table D.4: Pre-development Revolving Loan Fund FY 2009-10, through December 31, 2009	**FY**
Number of applications received that are eligible for the RLF.	6
Number of projects with a complete environmental review within 90 days	1
Number of projects with environmental clearance	1
Average amount of time from receipt of application to loan approval	-
Dollar ($) amount of loans distributed by LLC	-
Average length of time from loan close to loan maturity date	-
Average length of time from anticipated construction start to end date	-
Number of loans approved	-
Number categorized as predevelopment	-
Number categorized as land acquisition	6
Number of loans by Supervisorial District	
Supervisorial District 1	3
Supervisorial District 2	-
Supervisorial District 3	-
Supervisorial District 4	1
Supervisorial District 5	2
Number of special needs households to be served by each loan	42
Number of low-income households to be served by each loan	291
Number of proposed total and affordable housing units	333
Number of housing units to be developed at 60% or below AMI	291
Number of housing units to be developed at 35% or below AMI	42
Number of reports collected on time from LLC	1
Number/percent of lost loans (live to date)	-

Successes: The Los Angeles County Housing Innovation Fund (LACHIF) has been restructured. The Fund was anticipated to close in early January 2010.

Challenges: Current market conditions have made it difficult to attract new investors to the Fund.

Action Plan: The Low Income Investment Fund and CDC staff continue to market and negotiate with potential investors.

Client Success Story: Hudson Oaks, a 46-unit affordable housing senior community in the City of Pasadena, is requesting $3.7 million from the Fund, which would be the first loan to be financed by the Fund.

29) Project Homeless Connect

Goal: Provide individuals and families with connections to health and human services and public benefits to prevent and reduce homelessness.

Budget: $45,000 (One-Time Funding)

Project Homeless Connect (PHC) is designed to bring government, community-based, and faith-based service providers together, as well as other sectors of the local community, to provide hospitality, information, and connections to health and human services and public benefits to homeless individuals and families. PHC provides a unique opportunity for homeless individuals and families to access services in a supportive, community-based, "one-stop shop" setting. The Los Angeles County, Chief Executive Office (CEO) participates as the lead organizer for local PHC Day events, which normally take place during the first week of December; however, recent need and popularity of PHC Day has resulted in events on an ongoing, year-round basis. In December 2010, over 2,000 participants were connected to services through PHC.

Successes: Table D.3 shows the total number of PHC participants who were linked to emergency, transitional, and permanent housing by fiscal year.

Challenges: With the current economic condition and the fact that families and individuals are losing their homes due to property foreclosures, future Project Homeless Connect events will need to continue to target the at-risk population.

Table D.5: Project Homeless Connect

Fiscal Year	Emergency Housing	Transitional Housing	Permanent Housing
FY 2006-07	59	-	70
FY 2007-08	117	19	-
FY 2008-09	235	78	25
FY 2009-10	245	123	81
Total	656	220	176

V. CITY AND COMMUNITY PROGRAM (CCP)

Capital Projects

Successes: A total of nine capital projects are funded under the CCP, and the Bell Shelter project has been completed. The Community Development Commission (CDC) is in constant contact with all of the capital developers regarding the projects. The CDC has set up internal tracking systems to monitor project progress. The timeline for execution is being determined based on the need of each grantee. It is customary for grants to be executed near the start of construction. Loan agreements are being finalized for three capital projects.

Challenges: The progress of many projects has been delayed by the State budget freeze, and one project (Century Villages at Cabrillo) is still awaiting State funding. One project (Mason Court) is in need of additional gap financing.

Action Plan: Continuing from the previous quarter: the CDC is determining with each developer, whether or not to enter into the grant agreements soon or if it is best to wait until near the beginning of construction to avoid the necessity of several amendments. The CDC staff will provide technical assistance and conduct site visits to projects that are not under the oversight of any other public agency.

Cumulative Expenditures to Date: $5,823,533

Service Projects

Successes: To date, the Community Development Commission (CDC) has executed 15 service contracts that are in full implementation. Four additional service contracts will be executed upon completion of the capital component of these projects.

Programmatic and financial monitoring of projects began in September and continued through December, with our initial nine engagements completed and another three scheduled in the next couple of months. We plan to visit all agencies before the end of the Fiscal Year. The results so far reveal that the programs are being implemented as proposed and costs are properly supported. Only minor deficiencies in internal control and administrative procedures have been noted.

Most agencies have recruited program staff, and have developed subcontract agreements with their identified collaborators. Most have been expending funds, with the exception of two agencies planning to do so in the next months. To that end, the CDC has assisted a number of agencies in the submittal of payment requests and required documentation to support expenditures. Projects that had a slow start needed time to hire for key positions and to coordinate with subcontractors to ensure they meet all CDC requirements. Additionally, four service projects will not start until their capital project component is completed. At this point, with the downturn in the economy and difficulty with developers finding capital startup funds, the service component of some of these projects has been delayed.

Challenges: Cloudbreak Compton, one of the developers, notified us that they are not ready to begin construction at this time due to loss of funding. CDC has requested a meeting with Cloudbreak Compton to address their capacity to carry out the construction, and determine if contract should be terminated.

The City of Pomona Community Engagement & Regional Capacity Building has experienced delays in getting started. As requested by the CEO, a portion of this contract has been allocated to another homeless organization. The City has submitted a formal amendment request and revised scope of services and budget, which we have reviewed and approved. Next quarter, the City of Pomona will begin hiring staff, and submitting payment reimbursements.

The CDC currently has a vacancy in one of its two HHPF program Analyst positions. CDC is recruiting for this position and expect to hire within two months. In the meantime, the remaining Analyst, who is familiar with all of the HHPF programs, will cover all HHPF agencies until a replacement analyst can be hired and trained. No disruption in CDC services is anticipated.

Action Plan: CDC will continue to implement the programmatic and financial monitoring of the projects, which began in September 2009. Nine monitoring visits have been completed, and three more are scheduled for the coming months. CDC plans to visit all agencies on a quarterly basis and will adjust the priority of these visits based on the results of previous monitoring reviews.

Cumulative Expenditures to Date: $4,721,678

30. City and Community Program (CCP)

a. A Community of Friends (ACOF) – Permanent Supportive Housing Program
b. Ocean Park Community Center (OPCC) HEARTH
c. Catalyst Foundation for AIDS Awareness and Care –Supportive Services Antelope Valley
d. Homes for Life Foundation – Vanowen Apartments
e. Hope Gardens Family Center (Union Rescue Mission)
f. National Mental Health Association of Greater Los Angeles – Self-Sufficiency Project for Homeless Adults and TAY in the Antelope Valley
g. National Mental Health Association of Greater Los Angeles – Self-Sufficiency Project for Homeless Adults and TAY in Long Beach
h. Skid Row Housing Trust – Skid Row Collaborative (SRC2)
i. Southern California Alcohol and Drug Programs – Homeless Co-Occurring Disorders Program
j. Special Service for Groups (SSG)
k. Volunteers of America Los Angeles – Strengthening Families
l. Women's and Children's Crisis Shelter
m. City of Pomona: Community Engagement and Regional Capacity Building
n. City of Pomona: Integrated Housing and Outreach Program

30a) A Community of Friends (ACOF) - Permanent Supportive Housing Program
Budget: $1,800,000 (City and Community Program)

Table E.1: ACOF
July 1, 2008 – December 31, 2009

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	206	Education	87
Chronic Homeless	37	Job training, referrals	28
Homeless Families	125	Job placement	21
Female	339	CalWORKs	81
Male	293	General Relief w/Food Stamps	48
Transgender	1	General Relief only	4
		Food Stamps	4
Hispanic	148	Medi-Cal/Medicare	264
African American	361	Shelter Plus Care	207
White	109	SSI/SSDI	250
Asian/Pacific Islander	7		
Native American	-	Alternative court	3
Other	8	Case management	368
More than one race/ethnicity may be selected		Life skills	294
		Mental health	267
15 and below	186	Health care	174
16-24	72	Social/community activity	267
25-49	238	Substance abuse treatment (outpatient)	91
50+	137	Substance abuse (residential)	5
		Transportation	183
Moving assistance	12	Residential management support	176
Eviction prevention	52		
Rental subsidy	368	Case management (level 2)	
Housing (permanent)	368	Average hours per case:	7 hours
		Total number of hours:	7,410 hours
		Caseload:	16 cases

Longer-term Outcomes (at six or more months)	
Continuing to live in permanent housing	309
Receiving rental subsidy	309
Obtained employment	6
Maintained employment	21
Enrolled in educational program, school	40
Received high school diploma/equivalent	3
Case management	305
Health care	165
Good or improved physical health	161
Mental health care	230
Good or improved mental health	200
Recuperative care	4
Substance abuse treatment (outpatient)	78
Substance abuse treatment (residential)	3
No drug use	2
Reunited with family	4

Successes: A Community of Friends (ACOF) is pleased to report that the HPI funding has led to the continued successful collaboration with the Housing Works Mobile Integrated Service Team (MIST team). Collaboration with the MIST team continues to provide for intensive case management services for at risk tenants and tenants with specific needs. HPI funding also provides much needed on-going supportive services and case management and sites in need of such services. Additionally, HPI funding allows for additional supportive services through Resident Management support systems and provides for needed property maintenance. The ACOF case management staff, with the assistance of the MIST team, helped 293 formerly homeless individuals and families maintain housing stability for 12 months or more. Furthermore, 43 have maintained their housing for 18 months or more. The MIST team and case management staff have met regularly to ensure a continued overlay of needed services for “at risk” tenants, played an integral role in preventing evictions for those residents in jeopardy of losing housing, and case management staff has been able to ensure that the majority of residents remain permanently housed in a safe and healthy environment.

Housing Retention (N=368)		
All Current Tenants	341	93%
6 months or more	309	84%
12 months or more	293	80%
18 months or more	43	12%

Challenges: Significant differences were noted between the first status report and agency data. ACOF staff discovered some data had been miscalculated due to a combination of factors. The reporting tool has been a challenge because it is primarily directed at programs with new populations rather than those with existing populations such as permanent supportive housing. For this reason, data collection has been an ongoing challenge. This issue has been addressed numerous times with HPI staff and changes continue to be made to improve data collection. Data aggregation is also a challenge.

On the program side, challenges the tenants face include on-going struggles with substance abuse, correctly budgeting funds each month, managing medication, and improving life skills to a level which increases self sufficiency.

Action Plan: ACOF is working diligently with onsite supportive services staff to provide accurate report data. ACOF will be conducting a services department training to clarify the reporting process and introduce new tracking tools and monitoring procedures that will ensure the correct capture of data. In addition, ACOF has discussed with HPI staff and established baseline data from which to build upon. The baseline data, as reported in this current report, is accurate to the fullest and most reasonable extent possible. Case management staff will continue to work with the MIST team to focus on those individuals most at risk of losing their housing. In addition, case management staff will work with Resident Managers on "best practices" to increase support in those instances when case management staff are unavailable on nights and weekends.

Client Success Story: Tenant C is a 35-year-old female resident with two daughters ages eight and 15. She became homeless after a relationship abruptly ended and she did not have enough money to support herself and her two children. Many years before, she had been diagnosed with depression and borderline personality disorder and these life stressors only contributed to a reemergence of her symptoms. Her mental illness and the family's housing instability interfered with her ability to go to school, maintain a regular job, and have positive relationships with others.

Even after Tenant C and her family were permanently housed at Amistad Apartments, a project of A Community of Friends, she continued to struggle with her mental illness including dealing with issues of trust and low self-esteem. In addition, her constant complaints and negative comments towards others made it extremely difficult for her to get along with her neighbors. The onsite support staff worked diligently and persistently to develop a positive working relationship with this family. When the onsite residential services coordinator began working with Tenant C and her family, they met several times a week to address her numerous complaints about other residents. The residential services coordinator provided her with the time and space to vent that nobody else had before. In addition, onsite staff assisted her with mediating with her neighbors and diffusing the tensions among neighbors. This helped to gain her trust and provided a foundation from which to address her mental disability and the serious personal issues affecting her livelihood and wellbeing. After many months, onsite supportive services staff was finally able to help her refocus her energy on herself and her family and all the positive things that they were working on. This helped the resident reduce the amount of time she dedicated to complaining about others and learn to focus on the more positive things in her life.

With time and continuous support from onsite supportive services, Tenant C began making great strides in coping with her disability. Her self-esteem increased, her fear of failure decreased, and she became much more independent. She realized that it was acceptable and appropriate for her to take care of herself and she began taking better care of her overall health. In turn, this helped her to take better care of her family. In addition, she has been able to focus on achieving some of her goals such as getting a driver's license. For years she was consumed by fear and simply did everything possible to avoid taking her driving test. About six months ago, the residential services coordinator provided her with the latest copy of the DMV Driver Handbook and consistently encouraged her to begin studying the material. After months of putting it off, Tenant C recently worked up the courage to take her test and passed. She can now visit family and friends whenever she wants and she can finally begin working on her goal of operating a small business using her previous training and education. Despite being certified over 4 years ago, she never felt capable of using her skills and training to promote her business and increase her family's income. With her brand new driver's license, support from her new husband, and her new found self-esteem and motivation, for the first time in years, Tenant C is optimistic about her future. Tenant C is currently working to improve her credit and she and her family are saving up to attain the American dream of buying their first home.

	Quarter
Number of organizations that your program has a formal collaboration for this project	1
Number of times collaborative partners met each month	39
Total amount ($) of HPI funding leveraged for project	$1,775,550
Percent of HPI funding leveraged for project	33%
Number of participants who have enrolled into program during the reporting period	23
Number of participants who left the program during this period	8
Total number currently enrolled in program	341
Number of clients who received an assessment (if applicable)	23
Cost per participant	$2,645
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	24
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	9
Program Specific Question:	
Number of participants who received benefits (as a result of the program)	368

30b) Ocean Park Community Center (OPCC) HEARTH
Budget: $1,200,000 (City and Community Program)

Table E.2: OPCC HEARTH FY 2009-10, through December 31, 2009			
(unduplicated count)	**Cumulative**		**Cumulative**
Homeless Individuals	544	Education	-
Chronic Homeless	280	Job training, referrals	2
Transition Age Youth	47	Job placement	1
Female	289	Food Stamps	1
Male	582	Shelter Plus Care	5
		Section 8	7
		SSI/SSDI	1
Hispanic	66	Medi-Cal/Medicare	1
African American	243		
White	513	Case management	144
Asian/Pacific Islander	12	Life skills	22
Native American	6	Mental health	9
Other	31	Health care	871
		Social/community activity	35
		Recuperative care	106
15 and below	12	Substance abuse (outpatient)	9
16-24	74	Transportation	54
25-49	434	California identification	6
50+	351	Veterans	2
		Legal	3
Moving assistance	10	Locker	9
Housing (emergency)	40		
Housing (permanent)	23	Case management (level 3)	
Housing (transitional)	22	Average hours per case:	115
(Average 32 days in temporary housing)		Total number of hours:	345
		Caseload:	20
Longer-term Outcomes (six or more months)			
Continuing to live in permanent housing			4
Receiving rental subsidy			2
Case management			18
Health care			13
Good or improved physical health			11
Mental health care			1
Good or improved mental health			1

Successes:

- OPCC Project HEARTH provided 196 homeless individuals with primary health care from two Venice Family Clinic physicians co-located at OPCC Access Center.
- Twelve clients receiving health care became engaged in case management services.
- Ten clients achieved temporary housing (three individuals obtained transitional housing, seven individuals obtained emergency shelter).
- Nineteen individuals received respite care at OPCC Samoshel referred by Venice Family Clinic co-located at OPCC Access Center and two local hospitals (St. Johns Health Center and Santa Monica/UCLA Medical Center) with 47% obtaining temporary or permanent housing following a three week respite stay.
- Three clients received Section 8 vouchers or other subsidized housing and are conducting an apartment search.

Challenges:

- Lack of low-income housing options for medically vulnerable individuals who do not always qualify for federal housing.
- Lack of the necessary income to expand affordable housing options.
- Few housing and income resources exist for undocumented clients.

	FY
Number of organizations that your program has a formal collaboration for this project	4
Number of times collaborative partners met each month	2
Total amount ($) of HPI funding leveraged for project	$2,239
Percent of HPI funding leveraged for project	54%
Number of participants who have enrolled into program during the reporting period	196
Number of participants who left the program during this period	-
Total number currently enrolled in program	513
Number of clients who received an assessment (if applicable)	25
Cost per participant	$330
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	n/a
Program Specific Question:	
Number of participants who received benefits (as a result of the program)	17

Action Plan:

- Continue to improve the process of discharging homeless patients from the local hospitals into the respite program (through scheduled OPCC Project HEARTH orientations to hospital personnel).
- Refer housed clients for in-home supportive services.
- Utilize interns to assist staff in providing home visit support for clients.
- Utilize interns to look for alternative housing options.

Client Success Story: Client J, a 62-year-old veteran, has been chronically homeless for 20 years due to financial issues and mental illness. At the beginning of 2009, he was connected to OPCC Project HEARTH case management and primary health care. Initially he was resistant to housing, and staff worked diligently, encouraging him to access resources available to him. After accepting much support through OPCC Project HEARTH, the client entered the VASH Program, a federal housing program for homeless veterans. He received his VASH housing voucher in December 2009 after months of waiting and located an apartment in Santa Monica. He moved into his first apartment in January 2010, after living two decades on the street.

30c) Catalyst Foundation for AIDS Awareness and Care - Supportive Services Antelope Valley
Budget: $1,800,000 (City and Community Program)

Table E.3: Catalyst Foundation
FY 2009-10, through December 31, 2009

	Cumulative		Cumulative
At-risk Individuals	1,294	Education	386
At-risk Families	225	Job training	1
Homeless Individuals	24	Job placement	2
Homeless Families	15	CalWORKs	1
Chronic Homeless Individuals	12	General Relief	51
		General Relief and Food Stamps	4
Female	814	Food Stamps	1
Male	929	Medi-Cal/Medicare	5
Transgender	5	Section 8	2
		Case management	161
Hispanic	562	Health care	854
African American	553	Life skills	400
White	506	Mental health care	225
Asian/Pacific Islander	16	Transportation	145
Native American	10	Food	412
Other	83	Pet food/vet care	133
		Social/community activity	32
15 and under	23	Substance abuse treatment (residential)	1
16-24	646	Substance abuse treatment (outpatient)	2
25-49	573	Moving assistance	3
50+	241	Eviction prevention	10
		Rental subsidy	24
		Housing (emergency); avg. stay 120 days	1
		Housing (permanent)	2

Longer-term outcomes (six or more months)	
Continuing to live in housing	394
Obtained employment	2
Maintained employment	2
Case management	134
Health care	137
Mental health care	33
Substance abuse treatment (outpatient)	3
No drug use	3

Level 1 case management services	**Quarter**
Average for each participant per month	2 hours
Total hours for all participants	67 hours
Number of cases per case manager	67 cases

Number of organizations/agencies that your program has a formal collaboration for this project	33
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	$533,000
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	40%
Number of participants who have enrolled (entered) into program during the reporting period	426
Number of participants who left the program during this period	-
Total number currently enrolled in program	426
Number of clients who received an assessment (if applicable)	67
Cost per participant	$150
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	n/a
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	n/a

FY 2008-09 may include duplicated counts. For FY 2009-10 to date, a total of 295 individuals and 99 families were served; complete demographic information was provided for head-of-household.

Successes: The Catalyst Foundation continues to provide a continuum of services under one roof. We have been successful in informing existing clients who are homeless and at risk for homeless of the availability of our expanded services. These include clients who access medical care and supportive

services through the Catalyst clinic, as well as incarcerated teens and adults who participate in health educational programs at local prisons. A quarterly Catalyst Consumer Advisory Board Meeting was held during December, composed of clients who are representative of all groups served by Catalyst. This body meets quarterly to input consumer values, direction, development, implementation, and evaluation of Catalyst services. Moreover, they participate in activities such as outreach, creation of clinic and supportive services client materials. Furthermore, they provide feedback on stigma, discrimination and cultural competency issues. In addition, participants were able to form a leadership team where they presented recommendations on types of support groups that staff will begin to implement. Results from consumer surveys about the quality, timeliness, access to services, and an overall scores range between 4-5 on a scale of 1-5; 5 being excellent and 1 being poor. The program staff value participants' input and feedback and are committed to utilizing the tool to improve services.

Challenges: Due to the tough economic times and high rates of foreclosures in SPA 1; more people are trying to access program services. Currently, there is a waiting list with many people qualifying for services. However, it has been difficult to meet the needs of everyone applying for services.

Action Plan: The Director of Supportive Services will continue to train and support staff to provide assistance to participants. The waiting list for the food program will be reviewed weekly and clients that are on that waiting list will be contacted once an opening occurs. Volunteers work as part of our team to assist with the distribution of groceries and administrative/data entry tasks. The Director of Supportive Services will continue to meet with the data management team to come up with effective ways of collecting and reporting data. People on the waiting list are provided with information and referrals to other resources. Housing assistance and eviction prevention services are provided to those that meet the eligibility criteria. In addition, clients who meet criteria for the Recovery Act's HPRP program are referred to the City of Palmdale and Lancaster.

Client Success Story: Emergency housing was provided to a family of eight. They were in the process of moving into permanent affordable housing, when they were illegally asked to vacate their home. We immediately linked them to a housing rights center that provided assistance by educating and advocating for the family. In the meantime, the program placed the family in a hotel for one week, and they were finally able to move into safe, affordable housing. In addition, we assisted the family with a move-in assistance grant that allowed them to pay for their first month’s rent and security deposit.

30d) Homes for Life Foundation – Vanowen Apartments
Budget: $738,310 (City and Community Program)

Table E.4: Homes for Life Foundation – Vanowen Apartments
FY 2008-09, January - December 2009

(unduplicated clients) *	Cumulative		Cumulative
Homeless Individuals	13	Housing (permanent)	25
Chronic Homeless Individuals	2	Rental subsidy	25
At-risk Individuals	10		
		Case management	25
Female	10	Life skills	25
Male	15	Mental health care	25
		Substance abuse treatment (outpatient)	5
Hispanic	2		
African American	6	Medi-Cal/Medicare	25
White	13	SSI/SSDI	25
Asian/Pacific Islander	3	Social/community event	25
Other	1		
25-49	13		
50+	12		

Number of participants who have completed at least two life skills courses	-
Number of participants who completed at least two personal goals set forth in their ISP	8
Longer-term Outcomes (at six months)	
Continuing to live in housing	23
Receiving rental subsidy	23
Case management	23
Health care	23
Good or improved physical health	23
Mental health care	23
Good or improved mental health	23
Case management (level 2)	
Average for each participant per month	4 hours
Total hours for all participants	300 hours
Number of cases per case manager	12 cases
Number of organizations/agencies that your program has a formal collaboration for this project	10
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	-
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	-
Number of participants who have enrolled (entered) into program during the reporting period	1
Number of participants who left the program during this period	1
Total number currently enrolled in program	24
Number of clients who received an assessment (if applicable)	25
Cost per participant	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	-

Note: An unduplicated number of clients is provided in this report. Previous reports showed a duplicate number.

Successes: A total of 23 of 24 original residents have maintained their housing. One new tenant has settled in very well.

Challenges: The program experienced the loss of one resident who passed away during this quarter.

Action Plan: Clinical staff work closely with other residents to assist with additional counseling as needed.

Client Success Story: Client L is currently a tenant of HFLF, Vanowen Apartments. Before L occupied the apartment, he had his share of tumultuous events that included incarceration, physical injury, mental health struggles and other challenges. L recalls that he was on the waiting list for HFLF for over three years. During that time, he was in several transitional living programs, which provided him with a warm safe place to sleep, but he felt that he was not living up to his potential in those environments. When he

was accepted to HFLF, he was a bit overwhelmed, but after just three months in the apartments he felt that he had a new sense of purpose. Currently, L is thriving at the HFL Vanowen Apartments. He regularly accesses the services provided at the wellness center next door. He volunteers on a regular basis at a retirement home close to the apartments. He has taken job skills classes as well as held a part-time job. L also has made a large commitment to finding a creative outlet, by continually writing music, poetry and shorts stories which he reads with great pride to other residents and staff. L sees the apartment as a community. He invites people over for dinner and takes great interest and care with all the residents. L is a great example of how an individual in the right environment can be inspired to better their life. In closing, here is a quote from L. When asked what the HFLF apartments meant to him, he stated "HFLF does not guarantee I will not slip back into my mental illness, but it does give me the best chance of succeeding in all that I want to do with my life. I could not ask for a more supportive and caring place to live."

30e) Hope Gardens Family Center – Union Rescue Mission (URM)

Budget: $1,853,510 for services and $646,489 for capital (City and Community Program)

Table E.5: Hope Gardens
FY 2008-09, January - December 2009

(unduplicated count)	Cumulative		Cumulative
Homeless Families	60	CalWORKs	149
(individuals)	189	Food Stamps	152
		Medi-Cal/Medicare	144
Female	109	Section 8	5
Male	56	SSI/SSDI	6
		Veterans	3
Hispanic	43		
African American	79	Case management	87
White	25	Life skills	59
Asian/Pacific Islander	4	Mental health	78
Other	14	Health care	53
		Social/community activity	90
15 and below	95	Substance abuse treatment (outpatient)	33
16-24	16	Transportation	92
25-49	44		
50+	6	Case management (level 1)	
		Average hours per case:	15
Moving assistance	23	Total number of hours:	60
Housing (emergency)	10	Caseload:	11
Housing (transitional), *average 259 days*	146		
Housing (permanent)	20	Education	100
		Job training, referrals	40
		Job placement	18
Longer-term outcomes (6 months)			
Continuing to live in housing			6
Case management			2
Mental health care			1
Good or improved mental health			1
Substance abuse treatment (outpatient)			1
No drug use			1
Reunited with family			2

Successes: During the second quarter, the program transitioned three families (six individuals) of which two families (four individuals) relocated into permanent housing and one family (two individuals) transitioned back into emergency housing because of non-compliance, but subsequently the family was placed into permanent housing with the assistance of the Hope Gardens Case Management Team. During the course of this fiscal year, Hope Gardens transitioned nine of 42 families receiving services at our transitional living facility and 33 remain in the program. The families transitioned into the following areas:

- Eight families (17 individuals) were housed in Fair Market Housing.
- One family (five individuals) transitioned to a more appropriate transitional housing setting.

- One family (two individuals) was transitioned into emergency housing; but subsequently the family was placed into permanent housing with the assistance of the Hope Gardens Case Management Team.

Challenges: Hope Gardens, as a result of the downturn in the economy, is facing challenges in locating sustainable housing and employment options for families. The community is facing unprecedented challenges trying to secure affordable housing and the gap is widening. Many developers receive Tax Credits, but very few units are allocated to homeless families, especially those with substantial barriers. Set-aside affordable housing units are marketed to low-income residents, which widens the gap for hard to serve homeless families to qualify for housing. Many homeless families are ineligible for low-income housing, because they do not have sufficient income to meet the minimum income standards. Hope Gardens staff are addressing the challenges of each family individually and holistically to identify barriers that have kept them from achieving (and exceeding) their goals.

Hope Gardens Family Center continues to learn, evaluate and modify program services to meet the demanding needs of the diverse population. Many of families face additional challenges in the area of housing affordability. For example, most of the mothers do not have marketable job skills or a work history and continue to depend on housing vouchers from various programs. Many federally funded programs have been unable to secure or provide new vouchers, which leaves families frustrated and feeling like they do not have options. Other are burdened with the enormous task of securing living wage employment with minimal job skills. Still others have been unsuccessful in finding affordable/subsidized housing to meet their individual family needs.

Number of organizations/agencies that your program has a formal collaboration for this project	2
Number of times collaborative partners met each month	4
Total amount ($) of HPI funding leveraged for project	$249,600
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	41%
Number of participants who have enrolled (entered) into program during the reporting period	8
Number of participants who left the program during this period	6
Total number currently enrolled in program	106
Number of clients who received an assessment (if applicable)	3
Cost per participant	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	-
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	-

Action Plan: As a result of these economic hardships, Hope Gardens has increased resources and staffing in the Employment/Vocational Development Department to assist families in securing employment or increasing their skill/educational levels in this demanding economic market. The Hope Gardens Design Center has recently opened and women are working with Designers from the Fashion Industry to develop a career path. In collaboration with Raven & Lily, a full-time apprentice manages the design center. Hope Gardens has also appointed an additional four women as apprentices, which allows these mothers to put into practice a variety of new and expanded skills and at the same time receive a monthly stipend for their training hours. The Vocational Development team continues to work with potential employers to secure employment outside of Hope Gardens within six to nine months after any apprenticeship training. The program is proud to announce that one mother has secured employment with the County of Los Angeles as a Clerk. It is our hope that within the next six months she will have attained stability with her employment so that she and her son may begin the transitional process into sustainable permanent housing.

Hope Gardens is moving ahead with the final renovation phase for the Sycamore building, which will increase capacity by 13-15 additional families (10 double rooms). The program hopes to receive additional support staff to cover the increased number of guests. Program management consistently evaluates changes in the external environment and is working through challenges that are presented in program design and systemic barriers with families. This includes establishing very realistic and specific timelines and individualized service plans with each family without trying to fit them into a “one size fits all” mold that is unachievable for many families. It is the program’s goal to increase the number of families

being served until maximum capacity is reached and once renovations are completed on additional buildings.

Client Success Story: "I am a single mom of one child with a history of substance abuse. During my pregnancy I consumed substances and my child was immediately removed from my custody upon birth. I questioned myself, how would I secure custody of my son, I had made a terrible mistake. I did not know where to turn as my stay in the maternity home was being terminated and other alternatives seem a long shot. It appeared that I would not be able to reunify with my son unless I had some type of temporary housing stability. As a single mother without child the only options was SRO housing. However; we searched and found Hope Gardens which works with single mothers working through the Department of Children's and Family Services to reunify families. When I arrived at Hope Gardens, I was certainly in denial about my substance abuse history. I was angry and wanted to challenge the entire system of care but was counseled against causing any more damage to my case. I had a tremendous amount of classes, drug testing, drug treatment, visitation, and other additional requirements imposed by the Department. Throughout this process I found guidance, safety and refuge as the staff at Hope Gardens walked me through the process every step of the way. I did obtain custody of my son and am really proud of my accomplishments thus far.

I completed the Drug Treatment/testing program, parenting classes and others requirements and remain focused and sober. I would not want to face this type of challenge nor would I recommend any mother subject herself and/or her children to this type of trauma. Although my son was little and probably won't remember his removal, I had to fight to make sure that he was returned to my custody before he bonded with someone else. Throughout my journey however; I have found other mothers and children who were not so lucky, children who were removed and remember the trauma and the emotional scars that remain.

Union Rescue Mission/Hope Gardens has offered my family more than transitional housing; they have embraced every aspect of our lives. They made accurate assessments of my needs and helped me to focus on my primary goals. This was to regain custody of my son and obtain permanent housing. I am currently working towards returning to Florida where my family is awaiting our return. My family has committed to assist us with housing, either on our own or with my parents and I plan on returning to school to obtain my Bachelors Degree. We are still walking through this difficulty journey. I have a happy, well balanced son and with the loving support and knowledge shared with my family, I believe that we will be able to accomplish our goals."

30f) National Mental Health Association of Greater Los Angeles – Self Sufficiency Project for Homeless Adults and TAY Antelope Valley
Budget: $900,000 (City and Community Program)

Table E.6: Self Sufficiency Project for Homeless Adults and TAY Antelope Valley
FY 2008-09, January - December 2009

(unduplicated count)	Cumulative		Cumulative
Homeless Individuals	46	Shelter Plus Care	5
Chronic Homeless Individuals	67	Veteran's benefits	1
		General Relief and Food Stamps/GR	11
Female	52	Medi-Cal/Medicare	6
Male	61	SSI/SSDI	11
		CalWORKs	4
Hispanic	23	Case management	81
African American	62	Mental health	58
White	54	Health care	40
Asian/Pacific Islander	1	Social/community activity	30
Native American	2	Substance abuse treatment (residential)	2
More than one race/ethnicity may be selected		Substance abuse treatment (outpatient)	2
16-24	17	Transportation	74
25-49	67	Like skills	2
50+	29		

		Case management (level 3)	
Moving assistance	10	Average hours per case:	80
Eviction prevention	3	Total number of hours:	80
Housing (emergency)	2	Caseload:	30
Housing (transitional)	14	Average stay in emergency housing:	6 months
Housing (permanent)	20	Number to permanent housing:	4 participants
Education	3		
Job training	30		

Program Specific Measures	**Quarter**
Number of TAY who have obtained a technical school or college degree while in program	-
Number of participants who have a primary care physician	4
Number of participants who have a dentist	1
Number of participants with good or improved recovery status (substance abuse)	1
Longer-term Outcomes (at six months)	
Continuing to live in housing	28
Case management	72
Good or improved physical health	3
Good or improved mental health	78
Substance abuse treatment (outpatient)	25
No drug use	1
Reunited with family	2
	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	-
Number of times collaborative partners met each month	-
Total amount ($) of HPI funding leveraged for project	$78,658
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	80%
Number of participants who have enrolled (entered) into program during the reporting period	23
Number of participants who left the program during this period	31
Total number currently enrolled in program	103
Number of clients who received an assessment (if applicable)	23
Cost per participant	$698

Successes: The program successfully assisted members with move in costs which allow members to be placed in permanent stable housing.

Challenges: It has been challenging to have members follow through with continuous care and case management.

Action Plan: The program continues to research and locate more affordable housing as well as build more community relationships. Staff will continue to outreach and connect with distant members in the community.

Client Success Story: An extremely disabled member had no legal document, income housing, and her husband disappeared. Staff worked together and helped her obtain all legal documents, advocated and obtained SSI benefits for her. She is now in stable housing and doing well.

30g) National Mental Health Association of Greater Los Angeles – Self Sufficiency Project for Homeless Adults and TAY Long Beach
Budget: $1,340,047 (City and Community Program)

Table E.7: Self Sufficiency Project for Homeless Adults and TAY Long Beach
FY 2008-09, April – December 2009

(unduplicated count)	**Cumulative**		**Cumulative**
Homeless Individuals	55	Case management	67
Chronic Homeless Individuals	27	Job placement	17
Transition Age Youth	8	Benefits assistance/advocacy	3
		Bus tickets	*336
Female	15		*number of tickets
Male	75	Transportation	45
		Housing (emergency)	18

Hispanic	18	Average stay in emergency housing (day)	4
African American	25	Housing (permanent)	12
White	40	Rental subsidy	2
Native American	1		
Other	5	Job training	9
Demographics do not match total population.		Job placement	7
16-24	9	Mental health	27
25-49	42	Health care	2
50+	39	General Relief and Food Stamps	2
		Medi-Cal/Medicare	6
Case management (level 3)		SSI/SSDI	9
Average hours per case:	14		
Total number of hours:	428		
Caseload:	10		

Program Specific Measures	**Quarter**
Number of TAY who have obtained a technical school or college degree while in program	-
Number of participants who have a primary care physician	12
Number of participants who have a dentist	3
Number of participants with good or improved recovery status (substance abuse)	1
Longer-term Outcomes (at six months)	
Continuing to live in housing	6
Obtained employment	19
Maintained employment	14
Enrolled in education program, school	1
Case management	60
Health care	3
Good or improved physical health	1
Mental health	21
Good or improved mental health	17
Substance abuse treatment (outpatient)	1
Reunited with family	7

	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	1
Number of times collaborative partners met each month	-
Total amount ($) of HPI funding leveraged for project	$90,540
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	69%
Number of participants who have enrolled (entered) into program during the reporting period	31
Number of participants who left the program during this period	2
Total number currently enrolled in program	56
Number of clients who received an assessment (if applicable)	13
Cost per participant	$1,128

Successes: The Benefits Specialist attended several trainings on effectively attaining benefits and has put these new tools to use with positive results. He is now receiving award notifications for SSI from the Social Security Administration for individuals that he has been working with for many months. The Housing Specialist is continuing to build great relationships with local property managers/owners which increased her ability to locate permanent housing for the project participants. She is also very skilled at providing in-home case management to support people as they transition from homelessness to housing. The Day Labor Specialist is continuing to meet employers in the community and increase job opportunities for participants. He connected two individuals to education programs that will graduate them to high-paying positions and also connected two individuals to full-time employment.

Challenges: It continues to be a challenge to find affordable housing, and also linking people to the various low-income resources that they need in order to sustain rent for their apartments. There is substantial need for eviction prevention funds, and this is accessed through another agency and their application process. The program remains focused on reminding triage staff of the enrollment requirements of this program to ensure all eligible people are referred and enrolled.

Action Plan: This upcoming quarter, the program is focused on linking TAY participants to education resources. The Housing Specialist will be attending trainings related to finding affordable housing and housing retention for individuals who have experienced homelessness due to co-morbidity. The program will also explore ways to streamline the process of obtaining eviction prevention funds from partnering agencies.

Client Success Story: Client E came into the Drop-In Center experiencing both chronic homelessness and severe mental health symptoms. He was connected to a psychiatric nurse practitioner for mental health treatment and to the Westside Neighborhood Clinic for physical health treatment. He then met with the Benefits Coordinator who assisted him with an SSI application and court advocacy. In November, he received SSI and Medi-Cal benefits, providing him with the resources to pursue housing. The Housing Specialist worked quickly and assisted him with locating an apartment by mid-November. The client utilized almost every resource this program provides, and the quality of his life has dramatically improved.

30h) Skid Row Housing Trust – Skid Row Collaborative (SRC2)
Budget: $1,800,000 (City and Community Program)

Table E.8: Skid Row Housing Trust
FY 2008-09, January – December 2009

(unduplicated count)	Cumulative		Cumulative
Chronic Homeless Individuals	111	Case management	105
Female	32	Mental health	80
Male	79	Health care	76
		Life skills	64
Hispanic	6	Social/community activity	47
African American	91	Substance abuse treatment (outpatient)	76
Asian/Pacific Islander	19	Substance abuse treatment (residential)	5
Other67	1	Transportation	18
More than one race/ethnicity may be selected		Benefits advocacy	39
		General Relief and Food Stamps	11
		Medi-Cal/Medicare	14
16-24	2	SSI/SSDI	14
25-49	53	Legal	3
50+	56	Food	16
		Supervised volunteer work	24
Rental subsidy	111		
Housing (permanent)	111	Case management (level 3)	
Shelter Plus Care	111	Average hours per case:	8
Education	4	Total number of hours:	2,397
Job training	27	Caseload:	25
Job placement	5		
Longer-term Outcomes			
Continuing to live in housing			89
Receiving rental subsidy			89
Enrolled in education program/school			4
Case management			86
Health care			66
Good or improved physical health			58
Mental health			73
Good or improved mental health			62
Substance abuse treatment (outpatient)			65
Substance abuse treatment (residential)			3
No drug use			30
Reunited with family			63
			Quarter
Number of organizations/agencies that your program has a formal collaboration for this project			2
Number of times collaborative partners met each month			4
Total amount ($) of HPI funding leveraged for project			$206,925
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)			72%
Number of participants who have enrolled (entered) into program during the reporting period			7
Number of participants who left the program during this period			7
Total number currently enrolled in program			97
Number of clients who received an assessment (if applicable)			13
Cost per participant			$6,185
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter			3
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter			3

Successes: The integrated services staff put finishing touches on a new housing program called HealthyHome. This flexible, resident-initiated, strength-based program is designed to support tenants' recovery by helping them clearly identify challenges, set goals, and make healthy choices that facilitate achieving their goals. In addition to individual support provided by case managers and a recovery specialist, participants may choose from 30 on-site classes, groups, and activities as well as many off-site recovery oriented programs as part of their individualized HealthyHome program. The program launched in January 2010.

During February 3, 2009 to December 31, 2009, the program enrolled 117 residents. Twenty of these participants have left the program. Of the 97 participants in residents on December 31, 2009, 85% (82 residents) have been housed for over six months.

Challenges: No significant challenge was reported this quarter.

Action Plan: N/A

Client Success Story: This is a brief excerpt from "Changing Times", a monthly newsletter published by the Tenant Publications Committee. "This is my story" was written by a female resident living in the Abbey Apartments. "I am 44 years old and I have been addicted to crack cocaine for 28 years … Having the stability of permanent housing has allowed me to address my addiction and mental illness in ways that I could never have done on my own. Since living in the building, I have been able to address my mental illness by meeting with a trained psychiatrist and a therapist. I have been able to reconnect with my children and become the mother that I have always wanted to be. I continue to address my addiction by attending a 12 step meeting in the community, and I am honored to serve as the secretary for the Abbey's All Fellowship/12 Step Meeting. I am happy to report that I have been clean and sober for the past 20 months. I am very grateful for the advocates at Skid Row Housing Trust. Their support allowed me to have a second chance in life. And I have not taken this opportunity for granted. This is my story."

30i) Southern California Alcohol and Drug Programs (SCADP), Inc. - Homeless Co-Occurring Disorders Program
Budget: $1,679,472 (City and Community Program)

Table E.9: SCADP
FY 2009-10 through December 2009

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	111	Housing (transitional)	3
Homeless Families (individuals)	15 39	Mental health care	161
Transition Age Youth	20	Substance abuse treatment (residential)	75
At-risk Individuals	29	General Relief	4
Chronic Homeless Individuals	17	At six months:	
Female	52	Continuing to receive mental health care	10
Male	132	Good or improved mental health	9
Hispanic	91		
African American	29	Average length of stay for residents (days)	86
White	58	Residents discharged due to graduation	18
Native American	6	Discharge status for residents of transfer	3
Asian/Pacific Islander	1	Discharge status for residents of walk-out	8
15 and under	26	Discharge status for residents, violated rules	13
16-24	22		
25-49	119		
50+	24		

Number of participants who have enrolled (entered) into program during the reporting period	61
Number of participants who left the program during this period	32
Total number currently enrolled in program	64
Number of clients who received an assessment (if applicable)	61
Cost per participant	$800

Successes: This past quarter, the program began providing psychiatric services and therapy at two additional residential programs. Billing now occurs in a timely manner.

Challenges: More psychiatry hours are needed than the current psychiatrist has available. In addition, the program is looking into ways to capture 12 month and 18 month outcomes.

Action Plan: A second addiction psychiatrist is planning to join the team. The project director is collaborating with SCADP outpatient, in home, and supportive housing programs (to which some of the residential clients transfer to upon graduation) to allow clients to continue in the grant project after they are no longer in residential treatment. This will allow the grant to follow clients for longer periods of time, resulting in some 12 and 18 month outcomes. Most of these providers are open to allowing their clients to receive services from more than one SCADP program as long as the services do not overlap, the project director will keep them informed on all clients in their programs and will be responsible educate staff on a client's particular condition.

Client Success Story: A man reached the 12-month mark for receiving psychiatric services. He graduated from the residential program and moved into sober living. He met and slowly developed a relationship with a woman. She went off on vacation for one month, and his anxiety and depressive thinking began to bother him. He realized his insecurity and instead of automatically giving validation to his feelings and thoughts, he discussed them with the available mental health providers. He did some short-term cognitive therapy around his issues. Additionally, he looked for work continuously while in sober living with little success. He is a convicted felon; despite having his number retired, he was unable to secure a position. He did meet sober musicians and begin playing with bands again. After six months, an opening in his trade specialty became available. He was very excited. He understood the competition; however, he decided to apply and answer all questions truthfully. After a couple of interviews, he beat out the competition. He was exceedingly happy, because the employer knew he had been homeless, received treatment, had a felony, and had disappeared from his prior job because of his drug habit. He knew he was hired because of his skill and the changes he made in his life. In his depressive periods he had lost confidence in his abilities, but now he gained his confidence and worked to become independent.

30j) Special Service for Groups (SSG) – SPA 6 Community Coordinated Homeless Services Program
Budget: $1,800,000 (City and Community Program)

Table E.10: SSG
FY 2009-10 through December 2009

(unduplicated clients)	FY		FY
Homeless Individuals	53	Moving assistance	5
Homeless Families	80	Rental subsidy	17
(individuals)	240		
Transition Age Youth	7		
At-risk Families	40	Education	1
(individuals)	107	Job training/resources	33
		Job placement	5
Female	241		
Male	166	Case management	178
		Life skills	92
Hispanic	18	Mental health care	6
African American	371		
White	16	Other	41
Other	2	CalWORKs	4
		General Relief	2
15 and under	176	Section 8	3
16-24	55	SSI	5
25-49	184	Substance abuse treatment (outpatient)	1
50+	31	Transportation	17
		Food	2
Case management (level 3)		Eviction prevention	21
Average hours per participant per month	493	Housing (emergency)	55
Total hours for reporting period	1,478	Housing (transitional), average stay 11 days	43
Number of cases per case manager	21	Housing (permanent)	40

Longer-term Outcomes	
Continuing to live in housing	51
Receiving rental subsidy	2
Obtained employment	14
Maintained employment	27
Enrolled in education program/school	1
Substance abuse treatment (outpatient)	2
Substance abuse treatment (residential)	1
Number of organizations/agencies that your program has a formal collaboration for this project	6
Number of times collaborative partners met each month	1
Total amount ($) of HPI funding leveraged for project	$2,635,657
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	68%
Number of participants who have enrolled (entered) into program during the reporting period	94
Number of participants who left the program during this period	13
Total number currently enrolled in program	104
Number of clients who received an assessment (if applicable)	94
Cost per participant	$1,736
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the beginning of the quarter	20
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the end of the quarter	-

Successes: The program marked its second successful operating quarter of the stated contract. At six months follow up, the project presents an 83% housing retention rate for households who have remained in permanent housing after receiving eviction prevention or homeless services. SSG has found the online funding request process to be very efficient and effective. The financial reimbursement flow has been a smooth one. The open communication with the Homeless and Housing Program Fund analyst has made it possible to set key infrastructure procedures in place

Challenges: The lack of emergency and transitional housing facilities that accept intact families continues to be a challenge to keep families together. Most available temporary housing slots will only service single women with children or single males, but not both parents with children. A program specific challenge is the development of a database to efficiently collect quarterly report requirements. In addition, being pressed with time to produce quarterly reports slows down the development of a comprehensive database system.

Action Plan: Monthly collaborative meetings continue to take place to address the lack of intact family housing slots that are available. Contract partners meet to coordinate client services, strengthen community/partner relationships and build service capacity amongst members. In addition, as a larger division, the program will consolidate various homeless service providers' meetings for Service Planning Area (SPA) 6 into one convening per month. This would allow SSG as an agency to effectively be in sync with SPA 6 homeless service agencies and discuss systemic issues with a larger stakeholder group. With regards to developing a data collection system the Project Director has sought technical assistance through the CEO's office. The goal is to develop a data and outcomes tracking system using the Access software by the end of the fiscal year.

Client Success Story: One particular client success story that stands out this quarter is of a middle aged woman who is a testament to the current economic downfall. The woman found herself homeless after not only being laid off but also because her landlord sold the property in which she was living in without giving tenants proper notice. The client immediately began receiving supportive services once admitted. However, she was unsure of being placed in a shared living space through a transitional housing partner. The client insisted in finding temporary shelter elsewhere. She slept in her car, with friends and family, and would pay for a hotel with her unemployment earnings. While in the program, she referred a friend who took advantage of the transitional housing component to begin saving her money. Soon after she noticed her friend's progress toward financial and housing security, the client agreed to be placed with a housing partner Community Minded Business. Approximately 45 days after being in transitional housing, the client was able to regain stability by securing employment, adhering to a savings plan, securing a new permanent residence, and creating an emergency savings deposit to prevent future unexpected financial

crisis. The client is a success because of her determination and recognition of the benefits of moving through the program as it is intended.

30k) Volunteers of America - Los Angeles, Strengthening Families
Budget: $1,000,000 (City and Community Program)

Table E.11: VOALA
FY 2009-10 through December 2009

(unduplicated clients)	Cumulative		Cumulative
Homeless Families	66	Alternative court	6
(individuals)	296	Case management	251
At-risk Families	90	Life skills	158
(individuals)	447	Mental health	62
		Health care	39
Female	388	Social/community activity	135
Male	356	Substance abuse treatment (outpt.)	2
		Transportation	137
Hispanic	742	Food	114
Other	2	Medi-Cal/Medicare	97
		CalWORKs	41
15 and below	394	General Relief w/Food Stamps	17
16-24	97	General Relief only	2
25-49	238	Shelter Plus Care	1
50+	14	SSI/SSDI	11
		Food Stamps only	59
Eviction prevention	81	Section 8	47
Moving assistance	61	Legal	18
Housing (emergency)	17	Clothing	89
Housing (transitional)	6		
Housing (permanent)	12	Education	59
Rental subsidy	7	Job training, referrals	126
		Job placement	31

Average stay at emergency housing:	60 days
Number placed into transitional housing:	14 families
Case management (level 2)	
Average case management hours for each participant per month:	5 hours
Total case management hours for all participants during current reporting period:	286 hours
Number of cases per case manager:	22 cases
Longer-term Outcomes (at six or more months)	
Maintained permanent housing (through eviction prevention, linkages to jobs)	125
Receiving rental subsidy	10
Obtained employment	33
Maintained employment	36
Enrolled in educational program, school	30
Received High School Diploma/GED	5
Case management	217
Health care	81
Good or improved physical health	105
Mental health care	39
Good or improved mental health	115
Substance abuse treatment (outpatient)	2
No drug use	2
Reunited with family	4

Successes: During this reporting period, four families in the Strengthening Families program received security deposits, which enabled them to move into permanent housing. Once the families moved into their permanent housing, the case mangers' primary focus moved from finding permanent housing to linking families to community services and resources that would enable them to become self-sufficient. Additionally, the case managers worked with their families on finance planning, budgeting and how to navigate the public social services system. During the month of December, Strengthening Families was the lead agency for East Los Angeles that coordinated Project Homeless Connect Day 2009, where families who are homeless or at risk for becoming homeless were able to receive a multitude of services

and resources. With the assistance of over 35 community-based organizations, government agencies, and local business, the agency was able to serve over 300 families and individuals. Many of the families and individuals attending the event received same day assistance and many others were connected to various programs and services. Also for the month of December, all the families participating in the Strengthening Families program received food baskets, clothing, shoes and other much need items.

	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	5
Number of times collaborative partners met each month	4
Total amount($) of HPI funding leveraged for project	$1,000,000
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	50%
Number of participants who have enrolled (entered) into program during the reporting period	38
Number of participants who left the program during this period	6
Total number currently enrolled in program	133
Number of clients who received an assessment (if applicable)	75
Cost per participant	-

Challenges: Some of the challenges that the case managers have encountered during this reporting period are the lack of affordable housing units. The case manager's work with all their families on enrollment for Section 8 and conventional housing, but because of budget cuts and funding the waiting list for most affordable housing is a one to two year wait. Additionally, many of the families participating in the Strengthening Families program do not qualify for Section 8 or conventional housing because of the legal status so that poses an extra challenge for finding housing. Employment opportunities are very limited and the need for employment is very high. Many of the families that had been previously employed have lost their employment, and because of their legal status, they are unable to find employment. Many of the community resources in the past that have provided a safety net for families such as food banks are no longer as easy to access because of greater demand.

Action Plan: The program will continue to provide effective case management for families and connect with supportive services. Case managers are working closely with families on establishing a family action plan, so that they can better assist their families with their goals and objectives. The action plan includes but is not limited to money management, budgeting, and utilizing all available resources. Additionally, the case managers are working with families on opening saving accounts. The case managers will continue working with families that have not yet found employment by encouraging participation employment opportunities, employment readiness, resume writing, and successful interview technique classes. For the foreclosure and eviction cases, case managers have assisted by informing them about their rights as tenants and property owners. The case managers have also connected their families with a community based nonprofit legal organization that is assisting many the families with their situation at no charge.

Client Success Story: A family of six who had been living in their car was placed in emergency shelter, and with the assistance of a case manager was able to find and move into permanent housing. The case manager was able to assist the mother with finding employment and working with the father to find employment. The family's youngest child was enrolled into the Volunteers of America State Preschool/Head Start, a full-day child care program, thus the family does not have to worry about child care. The case manager also assisted families in enrolling families three other children in an after-school tutoring program that provides academic assistance to students who are homeless. With the assistance of the case manager, the family has established a family budget and savings plan and is working on moving to a permanent home.

30l) Women's and Children's Crisis Shelter
Budget: $300,000 (City and Community Program)

Table E.12: Women's and Children's Crisis Center (WCCS)
FY 2009-10 through December 2009

(unduplicated clients)	Cumulative		Cumulative
Homeless Families	65	15 and below	140
At-Risk Individuals	447	16-24	81
		25-49	234
Female	437	50+	23
Male	86		
		Case management	11
		Housing (emergency)	104
Hispanic	337	Housing (transitional)	4
African American	77	Average stay in days *(for quarter)*	23
White	47	Number to shared living w/friends or family	6
Asian/Pacific Islander	8	Life skills	21
Native American	1	Mental health care	54
Other	53	Transportation	63
Families are made up of individuals.		Job training	1
		Job placement	1

Case management (level 1)	
Average case management hours for each participant per month:	4 hours
Total case management hours for all participants during current reporting period	45 hours
Number of cases per case manager:	5 cases
Program Specific Measures	**Quarter**
Number of hotline calls that are related to domestic violence issues.	166
Number of hotline calls that are related to homeless issues.	159
Of the calls related to domestic violence, the number of families/individuals at-risk of becoming homeless.	92
Number of individuals reunited with their families.	-
Number of families who have enrolled (entered) into program during the reporting period	14
Number of families who left the program during this period	11
Total number of families currently enrolled in program	4
Number of clients who received an assessment (if applicable)	11
Cost per participant	$538
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	3
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	3

Successes: Both families in the transitional shelter continue to receive program services and are stable. At the beginning of the quarter, the emergency shelter returned to its normal program activities after a chicken pox outbreak affected the families. Six new families enrolled in the program at the beginning of the quarter alone. Throughout the entire quarter, seven families obtained temporary restraining orders. A client at the transitional shelter continues to attend English as a Second Language (ESL) classes.

Challenges: Finding transitional housing for the emergency shelter clients continues to be an obstacle. Only one family was accepted into long term housing during this quarter. The importance of keeping strict confidentially of the shelter is vital. One family broke confidentiality and was consequently asked to exit the program.

Action Plan: The program will continue to provide services to both emergency and transitional shelter clients. The Transitional Case Manager encouraged staff to help the monolingual Spanish clients speak and converse in English, and the clients English has improved over time.

Client Success Story: After many weeks of job hunting, mock interviews and resume writing workshops, one of the transitional shelter clients obtained a part-time job at the beginning of the quarter. The client relies on public transportation to get to and from work. The child care provider is flexible with the client's variable work schedule and continues to provide child care assistance. The client continues to receive individual counseling and attends support groups and parenting classes.

30m) City of Pomona: Community Engagement and Regional Capacity Building (CERC)
Budget: $1,239,276 (City and Community Program)

Table E.13: City of Pomona: Community Engagement and Regional Capacity Building
FY 2009-10, through December 2009

	FY
Number of groups included in Consortium	43
Number of community meetings that the CEM and Consortium members attended	-
Number of speaking engagements (by CEM and Consortium)	-
Number of key leaders engaged with Consortium meetings	-
Number of cities actively involved in Consortium meeting	-
Number of strategies developed to eliminate barriers to service and housing delivery	9
Number of legislative, zoning changes, etc.	-
Number of cities actively engaged in strategic planning and/or community activity	7
Number of cities that designate a point person on staff to work on implementing recommendations	8
Number of organizations/agencies that your program has a formal collaboration for this project	11
Number of times collaborative partners met each month	1
Total amount($) of HPI funding leveraged for project	-
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	-

Successes: The City of Pomona, the County Supervisors, and the San Gabriel Valley Council of Government (SGVCOG) have reached an agreement on the separation of $160,000 in HPI funds from the Community Engagement and Regional Capacity Building Program (CERC) to be used to support the complementary program developed by the SGVCOG.

Challenges: The CONSORTIUM must now quickly implement the CERC Program in order to bring unity and support to the regional effort to end homelessness.

Action Plan: The CONSORTIUM must seek advance funding in order to begin the funding cycle to support the planned services. Staff will be hired by mid-March and begin to move the Y!MBY Campaign and the interactive resources webpage and resource desk program components.

30n) City of Pomona: Integrated Housing and Outreach Program (IHOP)
Budget: $913,975 (City and Community Program)

Successes: The IHOP Program has been very successful in working with local landlords, property managers and management companies. For each client in need of eviction prevention services, their landlord has accepted and worked with the IHOP program. When a check could not be issued on the spot, landlords were willing to wait a week until a check could be issued to prevent the eviction. Landlords have also allowed clients to move in knowing a check will be mailed to them, which has helped reduce costs of motel vouchers.

Challenges: Finding appropriate housing for clients on fixed income (GR, CalWORKs, and SSI) continues to be a challenge. Many of the chronically homeless have fixed incomes, and unfortunately, $800 a month from SSI is not sufficient income to live in one's own apartment. Many chronically homeless people are not willing to accept affordable shared living.

Action Plan: As long as clients qualify for IHOP, they can be placed into appropriate housing whether in Pomona or other cities. Some Section 8 apartment complexes in the local area, as well as some properties at a distance, are available for rent as low as $199 a month. It is a challenge for clients to move far away, but by building a good relationship with the clients and landlords, greater success has been achieved by placing chronically homeless in distant housing. The Faith-based Committee began meeting in January 2010. A uniform client eligibility form is being developed for similar programs. Directory distribution is currently tracked manually. The webpage is live, and the tracking of webpage usage is being explored. Additional IHOP measure tracking is in development for the Pomona Continuum of Care Coalition.

Client Success Story: Client L is a 33-year-old male struggling with an addiction to alcohol and methamphetamine. He has a co-occuring mental health disorder. L suffers from seizures and is bi-polar. As such, L fits the definition of chronically homeless. He realized that in order to address his mental health issues, he needed to get into a detox program. L was placed into detox and, after completing the 10-day program, he moved into residential treatment. The client is now in stable housing, completing life skills training, and participating in counseling in a safe environment.

Table E.14: City of Pomona: Integrated Housing and Outreach Program
FY 2009-10, through December 2009

(unduplicated clients)	Cumulative		Cumulative
Homeless Individuals	13	Eviction prevention	12
Chronic Homeless	6	Housing (emergency), average 53 day stay	9
Homeless Families	17	Housing (transitional)	13
(individuals)	49	Housing (permanent)	17
Transition age youth	3	Job training	3
At-risk Individuals	3	Job placement	3
		CalWORKs	1
Female	48	General Relief (and Food Stamps)	1
Male	32	General Relief	1
		Case management	38
Hispanic	30	Health care	4
African American	51	Life skills	8
White	6	Mental health care	15
Native American	1	Social/community event	3
Other	1	Substance abuse treatment (outpatient)	3
		Substance abuse treatment (residential)	3
15 and below	36	Transportation	10
16-24	33	Food	8
25-49	35		
50+	26	Case management (level 3)	
		Average hours for each participant	69
		Total hours for all cases	207
		Average caseload per case manager	11

Average change in income for participants (annually)	$10,197
Number of agencies that use a uniform consent form	-
Number of agencies that received a current local Service Directory	43
Number of agencies active	37
Number of service delivery recommendations implemented by the Committee and PCOC	1
Longer-term Outcomes (at six months)	
Continuing to live in housing	6
Obtained/Maintained employment	4
Enrolled in education program/school	1
Case management	8
Health care	8
Good or improved health	8
Mental health care	2
Good or improved mental health	3
Substance abuse treatment (outpatient)	1
No drug use	7
Reunited with family	1
	Quarter
Number of organizations/agencies that your program has a formal collaboration for this project	18
Number of times collaborative partners met each month	3
Total amount($) of HPI funding leveraged for project	$71,553
Percent of HPI funding leveraged for project (total HPI funds/total funds leveraged)	100%
Number of participants who have enrolled (entered) into program during the reporting period	22
Number of participants who left the program during this period	5
Total number currently enrolled in program	22
Number of clients who received an assessment (if applicable)	25
Cost per participant	$310
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***beginning*** of the quarter	2
If transitional/emergency or permanent housing program, indicate the number of beds/units that were vacant at the ***end*** of the quarter	-

VI. COUNCIL OF GOVERNMENTS (COGs)

31a) San Gabriel Valley Council of Governments
Budget: $200,000 (On-going Funding)

In April 2009, a study team consisting of the Corporation for Supportive Housing, Shelter Partnership, Inc., Urban Initiatives, and McDermott Consulting, presented the San Gabriel Valley Regional Homeless Services Strategy Final Report to the San Gabriel Valley Council of Governments (SGVCOG). The final report included a summary of priorities presented by sub-regional cluster group and the following key issues were identified.

- First Priority: Permanent Supportive Housing
- Second Priority: Short-Term Housing (Emergency Shelter & Transitional Housing)
- Third Priority: Access Center

Implementation Strategy and Recommendations
A summary of five-year housing and service targets was presented by cluster group. Overall for the region, three strategic objectives, related recommendations, and a timeline were presented.

Strategic Objective I: Develop Leadership, Political Will, and Community Support

- Recommendation 1: Create a Valley-wide Membership Based Organization for the Primary Purpose of Education, Advocacy, and Coordination
- Recommendation 2: Meet and Confer with Municipal Leaders, Community Groups, Business Leaders, Faith-based and Community Service Providers within the San Gabriel Valley

Strategic Objective II: Build Provider Capacity and Expand the Service Delivery System

- Recommendation 1: Engage Community and Faith-based Service Providers in Planning, Training and Overall Capacity Building
- Recommendation 2: Create More Housing Opportunities for Homeless Persons in the San Gabriel Valley
  - √ 588 units of permanent supportive housing over the next five years
  - √ 150 emergency shelter beds and 300 transitional housing beds for single individuals over the next five years
  - √ Scattered-site housing programs to serve 100 families annually
- Recommendation 3: Create an Access Center in Cluster Five (Claremont, Diamond Bar, Glendora, La Verne, Pomona, and San Dimas)
- Recommendation 4: Develop Valley-wide Referral and Information Sharing System

Strategic Objective III: Leverage and Maximize Utilization of Available Financial Resources

- Recommendation 1: Form a San Gabriel Valley Supportive Housing Pipeline Review Committee
- Recommendation 2: Commit Local Investments from Municipalities Across Multiple Jurisdictions within the San Gabriel Valley to Stimulate Housing Production
- Recommendation 3: Utilize New Funding Opportunities to Expand Short-term Housing and Rapid Re-housing Programs

31b) PATH Partners/Gateway Cities Homeless Strategy
Budget: $135,000 (On-going Funding)

PATH Partners presented the Gateway Cities Homeless Strategy to the Gateway Cities Council of Governments (GCCOG). The first three categories (LEAD, ENGAGE and COLLABORATE) provide recommended actions that will build the leadership and infrastructure required to plan, develop and successfully start up the proposed programs and services presented in the IMPLEMENTATION category of the strategy.

The LEAD phase includes identification of a current or new regional leadership entity as well as designating a “Homeless Liaison” for each city. The ENGAGE phase involves formation of a stakeholder regional homeless alliance, implementation of “connections” strategies to engage the community, and

development of a public education campaign. Third, the COLLABORATE category focuses on enhanced government-wide collaboration. Specific strategies include: leveraging $1.2 million of County HPI funds to secure matching dollars within the region, exploring opportunities to secure funding from the American Recovery and Reinvestment Act of 2009, and organizing and coordinating the GCCOG cities to apply for additional funding; and coordinating a region-wide, multi-sector homeless collaborative event that integrates services and resources across agencies and departments, including government departments, service providers, faith groups and the business community. One example of an effective event that has produced demonstrated results in several communities are "Homeless Connect Days." The County of Los Angeles currently sponsors events that bring together hundreds of volunteers to engage homeless people and connect them to needed services all on one day.

The IMPLEMENT phase consists of four categories of implementation actions that are proposed as part of the Gateway Cities Homeless Strategy, which are all very closely intertwined and form a mini-"homeless strategy" in a region that effectively assists homeless individuals and families to move from the streets into housing and long-term independence –

√ **Homeless Prevention Services**: The region will create a minimum of two new homeless prevention programs over the next 12 months to provide prevention services to the homeless. A target goal is to have a total of four programs formed (one in each of the four group areas of the GCCOG region), over the next 3-5 years to provide accessible prevention services to those in need. Each homeless prevention program will serve 500 unduplicated individuals annually, providing screening and assessments, prevention programs and housing assistance.

√ **First Responders Program**: Geographic-based street outreach team(s) would serve as "first responders" and coordinate with local law enforcement, service providers, hospitals, businesses and others. Teams would be comprised of staff and/or volunteers, and would be multiPATH Partners 2009 disciplinary, utilizing staff from existing mental health providers, substance abuse treatment providers, county agencies, and faith groups. The GCCOG region will create a minimum of two new outreach teams over the next 12 months to provide outreach services to the Gateway Cities. A target goal is to have a total of four teams operating (one in each of the four group areas of the GCCOG) over the next 3-5 years to provide more accessible outreach services. Each outreach team will engage 80 new unduplicated homeless individuals and assist them in connecting to services annually.

√ **Interim Housing**: Develop a strategy to "rapidly re-house" individuals into interim housing, with the end goal of long-term housing. This approach will be linked to street outreach teams and will focus on intensive housing and placement assistance upon entry into interim housing, and will include linkages to housing subsidies, rental assistance programs and other supportive services. Cities/communities would place special emphasis on connecting existing interim beds and programs to street outreach, homeless prevention services, permanent supportive housing and other supportive services. The region will create a minimum of two new interim housing programs (30-40 beds per program) over the next 12 months. A target goal is to have four new interim housing programs (one in each of the four group areas in the region) over the next 3-5 years to provide housing. Each new program will serve 100 unduplicated homeless individuals annually, providing them with housing, case management and assistance in connecting to long-term housing opportunities and supportive services.

√ **Permanent Supportive Housing (PSH)**: Create a multi-year plan to increase the stock of PSH units in the GCCOG region. A proposed goal for the region is to invest in the creation of 665 units of PSH over the next five years (2010 to 2014). The production goal of 665 new units will double the number of available supportive housing units. The goal is based on an assessment of the available funding resources the GCCOG will be able to realistically access to support the creation of new PSH units. The breakdown of the 665 unit production goal over five-years includes: one 40 unit development, 175 units of smaller PSH projects and set aside units, and 450 scattered-site leasing units. A plan will be developed for acquiring further rental vouchers and/or creating more subsidized housing in the region for homeless families and single adults who do not require supportive housing but do require affordable housing in order to end their homelessness as they transition out of interim housing.